Public Services Ombudsman

10 Governor's Lane, Gibraltar

Annual Report 2017

Contents

Foreword

This is the 18th Annual Report of the Public Services Ombudsman.

I was appointed as Gibraltar's third Public Services Ombudsman on 1st April 2017. This followed the retirement of Mario Hook on 31st March 2017 after more than 14 years of dedicated service. His predecessor Henry Pinna, who was Gibraltar's first Ombudsman, served for 3 years.

I would like to publicly thank Mario for his excellent work during his tenure and to wish him a happy and well-earned retirement. I would also like to place on record the excellent work done by Henry Pinna during the initial years in setting up the Ombudsman's Office.

The work of the Ombudsman's Office has developed significantly over the last 17 years since it was first set up in 1998. The Office is now firmly established as an institution that provides an important check on Government Departments and other Public Service Providers. The impartiality and independence of the Ombudsman's Office ensures that the public is provided with an effective mechanism for highlighting and dealing with any maladministration or injustices caused.

The Ombudsman provides a service to the public that is impartial, independent and free of charge.

The investigations carried out by the Ombudsman's Office and the many recommendations made by the Ombudsman, which are invariably respected and followed by Government Departments and Public Service Providers, have made a significant contribution towards the improvement of our public services over the years.

Today, the Ombudsman's Office has an increasingly important role to play in our community. I am delighted to report that, upon taking up my appointment as Ombudsman, I have the support of a dedicated and highly competent team of officers at the Ombudsman's Office who are eager to help the general public with their specific complaints and who are fully committed to making a meaningful contribution towards improving the delivery of our public services for the benefit of the whole community.

Dilip Dayaram Tirathdas, MBE, JP
Public Services Ombudsman
28th February 2018

Main Report

Who is the Public Services Ombudsman?

Dilip Dayaram Tirathdas, MBE, JP,
BA, BSc (Hons), LLB (Hons), FCIB, Barrister-at-law

Dilip Dayaram Tirathdas is the current Ombudsman. He was appointed on 1st April 2017 upon the retirement of Mario Hook who served as Ombudsman for over 14 years.

The Ombudsman works together with a team of six officers:

Nicholas P Caetano, LLB (Hons), Barrister-at-law
Deputy Public Services Ombudsman, Head of Investigations and Staff Manager

Steffan Sanchez
Information Systems Support Executive Officer and Human Resources Manager

Nadine Pardo-Zammit
Executive Assistant to the Ombudsman and Public Relations Manager

Karen Calamaro
Executive Senior Investigating Officer and Finance Manager

Sarah De Jesus, BA (Hons), LLM
Executive Investigating Officer

Daniel Romero
Executive Investigating Officer

The Public Services Ombudsman and his Team:

What services does the Ombudsman provide?

The Ombudsman investigates complaints by the public about any acts or omissions by Government entities, agencies and authorities. This includes the Royal Gibraltar Police, the Gibraltar Health Authority, the Housing Works Agency and many other entities contracted by the Government to provide public services.

The aim of the Ombudsman is to 'put things right' for members of the public who may have suffered hardship or an injustice resulting from the maladministration or poor service by a Government department or authority.

What complaints can the Ombudsman investigate?

The Ombudsman normally investigates a complaint if this has not been adequately dealt with under the complaints procedure of the Public Service Provider concerned.

The Ombudsman will investigate a complaint against a Public Service Provider who has:

- failed to deal with a complaint adequately under its complaints procedure;
- not followed its established administrative rules, procedures and practices;
- failed to respond to letters or other correspondence promptly and satisfactorily;
- treated a complainant unfairly, unreasonably or in an improper manner;
- been careless or negligent in the service provided;
- taken a decision based on irrelevant grounds or based on incorrect or incomplete information;
- taken a decision without proper authority to do so;
- taken too long to deal with a matter, without reasonable excuse.

What complaints cannot be investigated by the Ombudsman?

There are some complaints against Public Service Providers that the Ombudsman cannot normally investigate. These include complaints where:

- the Ombudsman considers that the Complainant has an alternative and more appropriate remedy by way of proceedings in any court of law, board of enquiry or tribunal;
- the Ombudsman considers that the Complainant has a more appropriate remedy by way of legal action for a claim relating to medical negligence or malpractice by medical professionals.

The Ombudsman will therefore not normally look at complaints related to:

- Clinical judgment by medical professionals, including diagnoses and treatment;
- Negligence or Malpractice by Doctors and other Medical Professionals;
- Employment Issues such as recruitment; pay and conditions of employment; and contracts of employment; and
- Other issues that may be subject to legal proceedings before the courts or independent tribunals.

What remedies can the Ombudsman provide?

The Public Services Ombudsman can offer a range of potential non-judicial remedies, which can include but are not limited to recommending to the Public Service Provider that it should:

- provide an apology;
- give an explanation;
- correct an error;
- change its practices, procedures and systems.

Proposed Review of Health Complaints Procedure

The Gibraltar Ombudsman's Office was given jurisdiction to investigate complaints against the Gibraltar Health Authority in April 2015.

A Complaints Handling Scheme Office ("CHS") was established to operate at arms-length from the Ombudsman's Office. The CHS is based in the Hospital and deals with all such complaints, in the first instance.

Those complaints that cannot be resolved following an investigation by the CHS are referred to the Ombudsman's Office for a more in-depth and exhaustive investigation. Some of these complaints are referred to clinical advisers in the United Kingdom for their opinion on the issues being investigated.

In addition to the avenue currently available for making complaints to the Ombudsman at CHS, a Patients Advocacy and Liaison Service ("PALS"), has been set up by the GHA as a further avenue for dealing with customer queries and complaints, in the first instance. The PALS Office is also based in the hospital.

It is clear, however, that there is room for improvement in the way that complaints at the GHA are dealt with. Many of the complaints currently being received by the Ombudsman's Office could have been resolved easily and expeditiously by the GHA themselves.

I have therefore recommended that there should be a single office at the hospital for dealing with complaints, rather than the present two offices. I am currently working on drawing up guidelines on the procedure for making and dealing with complaints in order for these to be clear to complainants and so that issues can be addressed efficiently and expeditiously, In my view, the service provided by the CHS should be merged with that of PALS and this would greatly improve the service being provided to complainants.

INTERNATIONAL MEETINGS AND SEMINARS

Semi-annual meeting of the Public Service Ombudsmen ('PSO') Group - held at Gibraltar House in Brussels, on Wednesday 21st June 2017

The Public Service Ombudsmen ('PSO') Group held its semi-annual meeting at Gibraltar House in Brussels, on Wednesday 21st June 2017.

PSO Group meetings provide Public Services Ombudsmen with a forum for the exchange of ideas at first hand and an opportunity to discuss areas of common interest. The PSO meetings also enable Ombudsmen to provide each other with updates on the work carried out in their respective countries and offices.

The PSO Group meeting in Brussels was chaired by the Public Services Ombudsman of Gibraltar, and attendees included the Public Services Ombudsmen of Ireland; Northern Ireland; Scotland; and Wales; the United Kingdom Parliamentary and Health Service Ombudsman; the Local Government and Social Care Ombudsman; and the Parliamentary Ombudsman of Malta.

The meeting was hosted by the Public Services Ombudsman of Gibraltar, Dilip Dayaram Tirathdas and his team, Nicholas Caetano - Deputy Ombudsman and Nadine Pardo-Zammit - Executive Assistant to the Ombudsman.

Photo from left to right: Nick Bennett, Wales PSO; Marie Anderson, Northern Ireland PSO; Rosemary Agnew, Scotland PSO; Peter Tyndall, Ireland PSO, Rob Behrens CBE, United Kingdom PHSO; Michael King, United Kingdom LGO; Dilip Dayaram Tirathdas MBE JP, Gibraltar PSO; Sir Graham Watson; Paul Borg, Director General Office of the Ombudsman of Malta; Anthony Mifsud, Malta PSO; Nadine Pardo-Zammit, Executive Assistant to the Gibraltar Ombudsman; Donal Gallighan, Director of the Ombudsman Association; and Nicholas Caetano, Deputy Ombudsman of Gibraltar.

The PSO meeting followed the 2017 **Annual Conference of the European Network of Ombudsmen,** which was also attended by the Gibraltar Ombudsman and his team.

Participants in the 2017 annual conference of the European Network of Ombudsmen, which took place in Brussels on 19-20 June 2017

Semi-annual meeting of the Public Service Ombudsmen ('PSO') Group held at Gibraltar House in Manchester, on Tuesday 14th November 2017

At the PSO Group meeting of 14th November 2017, a revised guide to the Principles for Remedy applicable to Public Services Ombudsmen was approved unanimously by the eight Public Services Ombudsmen who attended the meeting.

The agreed Principles for Remedy are as follows:

Public Services Ombudsmen – Principles of Remedy

What is the purpose of this guide to the Principles for Remedy?

This is a guide to explain how Public Services Ombudsmen in the United Kingdom and Ireland, Malta and Gibraltar (the Ombudsmen[1]) aim to put things right for members of the public who have suffered injustice or hardship resulting from maladministration or poor service by a public body in their jurisdiction. This guide outlines the Ombudsmen's general approach to recommending remedy for injustice and is based on the PHSO Principles for Remedy. In setting out six guiding Principles for Remedy, the aim is to achieve a consistent approach to remedy by the Ombudsmen. It is important that both members of the public and public service providers in their jurisdiction are aware of how decisions on an appropriate remedy for injustice resulting from maladministration have been arrived at in any case. These Principles for Remedy are an agreed framework for the Ombudsmen to reference in order to inform, where appropriate, their approach to remedy.

[1] In this document, Ombudsman and Ombudsmen are to read as interchangeable.

What do we mean by remedy?

Identifying and where possible remedying an injustice or hardship caused by a body's maladministration or poor service is a key function of an Ombudsman. Members of the public when making a complaint to an Ombudsman are invited to identify the remedy or outcome they seek. This is important so that the Ombudsman can decide whether or not an alternative legal remedy exists for the injustice complained of, as there may be a more appropriate course of action for the complainant to pursue. Ombudsmen offer a flexible range of potential non-judicial remedies that can be applied in any case. Ombudsmen remedies can include but are not limited to:

- an apology
- an explanation
- correction of an error
- an agreement to change practices, procedures or systems
- financial redress

How can this guide be used by Ombudsmen?

It is a matter for each of the Ombudsmen to decide on an appropriate remedy based on the identified maladministration and injustice suffered by the individual in any case. This guide is not intended to limit the Ombudsmen in the exercise of their discretion in any particular case. The Ombudsmen's Principles for Remedy are intended as an agreed normative framework to inform their approach to remedy where public services have been found to have failed and also as a reference point for Ombudsmen when developing more detailed guidelines relevant to their particular legal framework.

The Principles

Principle 1: To Put things right

The overarching principle when considering a remedy for injustice is to restore the individual back to the position they were in prior to the maladministration or poor service taking place. That may include recommending the award of the benefit to which the individual was entitled but had not received because of the failings of the public body concerned or recommending payment for a loss suffered as a result of the maladministration. Ombudsmen may also recommend payments for upset or 'time and trouble' where appropriate.

However, the outcome of maladministration or poor service cannot always be rectified or circumstances reversed. In such cases by offering a particular remedy the Ombudsman seeks to, at the very least, remedy the injustice sustained by the individual.

In a particular case 'Putting things Right' may also require a consideration of remediation for the public in general. In cases where the maladministration affects more than one individual because systemic failings have been identified, the Ombudsman will seek to remedy this by making recommendations in the public interest for systemic change.

Putting things right might also involve an Ombudsman drawing the attention of the relevant governing body (Parliament, Assembly, or full council of the relevant local authority) to a specific legislative failing which has resulted in an injustice.

Principle 2: To be open and accountable

The Ombudsman should be open and clear about the reasons why they have recommended a certain type of remedy. This includes publishing on their website their specific policies on remedy and providing detail of the injustice they are seeking to address by their recommendation, as well as explicit reasons for that recommendation in their report to the body and complainant.

Where a body fails to comply with a recommendation this will be reported openly and publicly to the relevant Parliament, Assembly or full council of the relevant local authority, so that the public body is accountable for its actions.

To enable public bodies to be aware of Ombudsmen's recommendations for remedy in particular cases, these will be reported on in an annual report and case digest which will be published.

Principle 3: To be empowering

The Ombudsman will take into account the views and circumstances of the complainant and consider what remedy they are seeking. In addition, where appropriate, the Ombudsman will consider the views of the complainant in relation to the issue of remedy. However, at the outset the Ombudsman should manage the expectations of a complainant regarding remedy and redress, and what can be achieved as ultimately, the Ombudsman will decide what is an appropriate remedy within the scope of his/her remit, in any particular case.

Principle 4: To be fair, reasonable and consistent

The Ombudsman will treat each case on its own merits and consider the specific circumstances of each case, ensuring that the remedy recommended is reasonable once all aspects of the injustice have been considered.

Ombudsmen may delegate decision making to staff in their offices in relation to recommending a remedy in certain cases. However, Ombudsmen will ensure that in deciding on an appropriate remedy, there is consistency with previous decisions and also a consistency in approach in reaching a decision about what is an appropriate remedy. In the case of a recommendation for financial redress, consistency does not refer to the monetary amount offered for a particular type of complaint. Where the Ombudsman is recommending financial redress and as no two complaints are ever exactly the same, the Ombudsman will consider carefully the nature of the injustice sustained and whether it is possible to put the person back in the position they would have been in but for the maladministration or service failure identified.

The Ombudsman will seek to be fair and act without bias or prejudice in addressing individual cases for remedy. To ensure a fair process the Ombudsman will indicate to both the complainant and the public body in advance of a final report on an investigation his/her considerations for remedy (in draft form) and will consider the parties views. Although, ultimately, the final recommendation is a matter for the Ombudsman.

Principle 5: To be proportionate

The Ombudsman will recommend an appropriate remedy which is fair and proportionate in all the circumstances and having particular regard to the nature of the injustice caused to the complainant by the maladministration or poor service.

Principle 6: To monitor and ensure compliance

Public Service Ombudsmen have powers to bring to the attention of their legislature (that is Parliament or Assembly or the full council of the relevant local authority) where a recommendation has not been met by the body. This is an important function of an Ombudsman as it is to the relevant legislative or governing body that he or she must report the failings in such circumstances. This in turn requires an Ombudsman, as a matter of good practice, to check routinely with public service providers to ensure that a recommendation has been fully complied with. Failure to comply with an Ombudsman's recommendation may be the subject of a 'special report' by the Ombudsman to the relevant legislature or governing body as this failure can constitute maladministration.

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Approved on 14th November 2017 by the following Public Services Ombudsmen:

Marie Anderson
Northern Ireland Public Services Ombudsman

Nick Bennett
Public Services Ombudsman for Wales

Peter Tyndall
Ombudsman & Information Commissioner for Ireland

Dilip Dayaram Tirathdas
Gibraltar Public Services Ombudsman

Anthony Mifsud
Parliamentary Ombudsman - Malta

Rob Behrens
Parliamentary & Health Services Ombudsman

Mick King
Local Government Ombudsman & Chair of the Commission for Local Administration in England

Rosemary Agnew
Scottish Public Services Ombudsman

The 24th Annual General Meeting and Conference of the Ombudsman Association - held at Loughborough University on 25th and 26th May 2017

Our Head of Investigations and Deputy Public Services Ombudsman, Nicholas Caetano, attended the Ombudsman Association ("OA") 24th Annual General Meeting ("AGM"), which was held at Loughborough University. He also participated in the 2-day Conference that was held thereafter, entitled "Holding up a Mirror".

The Gibraltar Public Services Ombudsman is a fully participating voting member of the OA. During the AGM, the annual accounts of the OA were approved and a number of new members were elected to serve on the Board.

Various speeches were delivered during the Conference, with 'introspection' being the central issue considered. Delegates were also addressed on issues such as 'taking time to reflect on complaints'; 'international best practice on how to be more effective in the handling of complaints'; and, 'being customer focussed', which consisted mainly on the objective assessment of cases on their own merits.

Other workshops included 'consistency in casework and quality assurance' which consisted of a panel session run by the Casework Interest Group and which analysed the different quality assurance approaches taken by members to ensure consistency. This workshop was of particular interest as indeed was the workshop on 'Incorporating Human Rights', which explored the application of human rights issues in casework.

Ombudsman Association's Casework Interest Group Meetings - held in London on 12th May and 3rd November 2017

The biannual meetings of the Ombudsman Association Casework Interest Group were held in London on 12 May 2017 and 3rd November 2017. The first meeting in May 2017 was hosted by the Gibraltar Public Services Ombudsman at Gibraltar House in the Strand, London, and the second meeting in November was hosted by the United Kingdom Financial Services Ombudsman, at the Exchange Tower in Canary Wharf, London.

The Gibraltar Public Services Ombudsman was represented by our Senior Investigating Officer, Karen Calamaro. There were over 20 attendees at each of these meetings from numerous organisations within the United Kingdom and Ireland.

Casework Interest Group meetings provide a forum for discussion for professionals in the Ombudsman field. They also provide an excellent opportunity for delegates to advance on concepts and ideas which will undoubtedly result in a better service to the public.

Training for caseworkers has been a matter of discussion for the Human Resources Interest Group for some time and the setting up of a Caseworker Competency Framework is presently under way.

Due to the significant increase in the number of complaints, most of the organisations represented at the meeting have reduced the length of their reports - in some cases these were previously between 30 to 40 pages long. It was noted that this action has had a positive result with cases now being concluded faster and with no negative effects having been noted with regard to complainants.

Attendance at Seminars and Courses held locally

Mental Health First-Aid Course - held at University of Gibraltar on 10th and 11th October 2017 and on 15th and 16th December 2017

Our Investigating Officers, Karen Calamaro, Nadine Pardo-Zammit and Sarah De Jesus attended a two-day Mental Health First-Aid Course organised by Clubhouse Gibraltar. The course was held at the University of Gibraltar.

The purpose of this course was to inform and familiarise attendees about mental health issues with the aim of equipping them with the skills to enable them to provide mental health first-aid when a situation arises. The main objectives of the course were for attendees to be able to:

- preserve life when the person may be at risk of harm;
- provide help and information to prevent mental health issues from becoming more serious before professional help arrives;
- promote the recovery of good mental health;
- signpost the person to other agencies or organisations for assistance where this may be necessary;
- raise awareness of mental health issues ;
- reduce stigma and discrimination of Mental Health Issues; and
- improve the person's health and well-being.

The course was delivered by Daryl Britto, from Positive Pathways, and Kevin Fowler, from Clubhouse Gibraltar. They each have extensive knowledge and experience in dealing with persons suffering from mental health issues and their delivery of the course was excellent.

Ombudsman's 2017

Casebook

Case Summaries

Gibraltar Health Authority

Case 1

Background

The complaint related to the care received at St Bernard's Hospital by his late 92 year old mother (a vulnerable patient) and in particular the manner in which she was discharged from the hospital and transferred back to the Elderly Care Agency ("ECA").

The patient was admitted to hospital with a neck fracture following a fall whilst in the care of the ECA. She was discharged from the hospital and transferred back to the ECA on the same day, after an assessment had been made by the hospital's Occupational Therapy Department ("OT").

The Head of OT made a number of recommendations for the patient's ongoing care, including the type of specialist chair that was required by the patient and details on how the patient should be moved and positioned, in view of her neck injuries.

However, the type of specialist chair that was recommended by the OT was not available at the ECA and the OT's recommendations for seating and positioning that would be required by the patient could not be provided by the ECA.

The patient was nevertheless discharged from the hospital and transferred back to the ECA. It was this action by the GHA that was said to have contributed to a rapid deterioration in the patient's health.

Investigation and Findings

The Ombudsman reviewed the relevant correspondence and medical notes in the GHA files and also sought independent specialist clinical advice from an expert occupational therapy assessor in the United Kingdom.

The Ombudsman found that the Head of OT at the hospital had received a notification from the Residential Doctor at the ECA that the type of specialist chair being recommended was not available at ECA and that no OT cover would be available for the patient at the ECA.

However, the Head of OT was of the view that OT's responsibility and liability for their patients ended upon their discharge from the hospital. However, it became clear to the Ombudsman, following the expert's advice, that this view was mistaken and that this was clearly not in line with The College of Occupational Therapists Code of Ethics and Professional Conduct.

Paragraph 2.5.3 of the Code, which was highlighted by the expert in his report, states:

> "When care for the service user is shared with or transferred to another practitioner or service, you must co-operate with them to ensure the health, safety and welfare of the service users."

Paragraph 3.1.3 of the Code, further states:

> "Your duty of care would not necessarily stop at the point when a person is discharged from your service. Only when you have referred the service user to another agency, if appropriate; complied with all the necessary procedures; taken reasonable action to ensure the service user's safety and ensured that a follow up is not reasonably required, then you will have no further responsibility or liability."

In this case, it would have been reasonable for OT to check and ensure that the specific type of equipment that had been recommended by them was at the very least available to the ECA before arranging to discharge the patient and transfer her back to the ECA.

It would also have been reasonable for OT to review the position after the patient's discharge to ensure that their recommendations for this patient were being followed by the ECA correctly.

It is clear that the GHA agreed to discharge the patient without ensuring that the recommendations that would have supported the patient's ongoing treatment and care at the ECA could and would be carried out. Reasonable action to ensure the patient's safety was, therefore, clearly not taken.

Recommendations and Outcome

The Ombudsman communicated his findings to the GHA's management and recommended that:

i) practitioners at the GHA ensure that Professional Codes of Conduct are strictly adhered to;

ii) before discharging or transferring patients to other care agencies, GHA departments should liaise with the relevant agency concerned to ensure that any recommendations made by practitioners for the patient's safety and ongoing treatment and care can be adequately carried out, in accordance with good and established practice;

iii) the GHA issue the Complainant in this case with an appropriate letter of apology.

The GHA's Medical Director agreed with the Ombudsman's recommendations and these have been duly adopted by the GHA.

Gibraltar Health Authority

Case 2

Background

The Complainant was the Patient's niece. She explained to the Ombudsman that the Patient's daughter ("the daughter") had found the Patient lying in a pool of blood on the floor of her apartment (the Patient lived on her own). The daughter had then contacted the emergency services and immediately after that had also contacted the Complainant.

When the Complainant arrived at the scene, at around 9.45 am, the Royal Gibraltar Police ("RGP") were already in attendance but she was not permitted by the RGP to enter the premises. The Complainant explained to the Ombudsman that the RGP had been unable to contact a General Practitioner ("GP") at Saint Bernard's Hospital ("SBH") in order to attend the premises to confirm the death and the Patient could not be moved until this GPs certificate was provided. This had resulted in the Patient having had to remain in the apartment, lying in a pool of blood on the floor, for approximately eight hours before the GHA's duty doctor was available to attend.

Investigation & Findings

The Ombudsman found that when the RGP had to contact the GHA's duty doctor to attend such cases, the RGP used the same GHA telephone line as is used by the public. The GHA public telephone line is not in operation during a three-hour period each day between the hours of 11 am and 2 pm. This was the main reason which contributed to the lengthy delay by the RGP in being able to contact the duty doctor to attend the scene in order to confirm the Patient's death and to arrange for the transfer of the body to the mortuary.

The Ombudsman discussed the matter with the GHA's Medical Director and also met with the Director of Public Health. They both identified that there was a need to improve the system and procedures in such cases.

The Director of Public Health explained to the Ombudsman that their general rule was that 'the living take precedence over the dead' and that it 'would not have been ethical for the duty GP to have left ill patients' in order to attend to a deceased patient.

Although the established procedures had been correctly followed by the RGP, it was clear to the Ombudsman that there was a flaw in the established system in place and that a better system was required for the RGP to be able to establish contact with the GPs on duty at the hospital, when necessary.

Recommendations and Outcome

The Ombudsman found that there had been maladministration on the part of the GHA in this case.

It was unacceptable for the GHA not to be in a position to ensure that a GP was made available in a timely manner in order to attend such cases. The grief and disrespect caused to the family could have

and should have been avoided. The Ombudsman recommended that the procedures in place should be improved.

The Ombudsman followed this up further with both the GHA's Medical Director and the Director of Public Health and recommended that they look into the matter in order to find a way to improve the procedures in place and also to implement a more efficient and effective system for the RGP to be able to access the doctor on duty.

Gibraltar Health Authority

Case 3

Background

[*Ombudsman Note: The background is mainly based on the version of events provided by the Complainant, including supporting documentation, at the time of lodging the Complaint with the Ombudsman*].

The Complainant complained to the Complaints Handling Scheme ("CHS") that on the 6th June 2016 the Service Users, who the parents of the patient and who were both deaf, texted the Primary Care Centre ("PCC") for an early morning appointment. They had been previously advised to seek the appointment prior to the switchboard opening to the public. The text remained unanswered for twenty minutes. Apparently, the delay was due to the operator handling the answering system being unfamiliar with the procedure applied to deaf service users.

The Service Users had requested a general practitioner ("GP") appointment for their youngest son ("the Patient"). Mid-morning that same day, they were seen by the GP but a failure in the Sign Video system did not allow the GP to access said facility. The GP tried signing in several times to no avail. She was sympathetic and apologetic but as a result, the consultation was undertaken without the effective communication necessary.

On a separate instance the Patient and the Service Users attended Accident and Emergency ("A&E") and were seen by the A&E doctor ("the Doctor"). The Complainant stated that they had been seen by the Doctor on two prior occasions and that in this instance, he made it a point of ignoring the Service Users. He had allegedly repeatedly placed his "extended arm with palm facing out within a foot" of [the Service User's face] when she tried to speak.

The Complainant was of the view that the Doctor's behaviour was unethical and unprofessional. He stated that it could only be the result of terrible medical ethics, ignorance and bad manners.

The Complainant explained that on that day at A&E, having had enough humiliation from the A&E Doctor, they requested to be seen by another doctor at the Unit. They were attended to by an alternative practitioner who treated them with the respect and professional manners they would have ordinarily expected.

The Complainant believes that GHA staff require training for the proper use of the facilities available for deaf patients. The Complainant stated that the deaf, as well as every other person forming part of a minority, should not have to be subjected to humiliation due to a lack of professional medical development.

The Complainant made the following suggestions in relation the Sign Video system to ensure its effective functioning for service users and providers:

1. All members of the GHA need to familiarise themselves with the protocols for effective use of the Sign Video system;

2. All new members of staff should be inducted on the use of it;

3. Doctors must understand that the use of Sign Video is crucial and "not optional";

4. Members of staff need to adopt a practice of testing the facility prior to daily use at consultations;

5. The facility must include a function where doctors and nurses are alerted that they hold a Sign Video appointment that day - this will allow them enough time to test the function of the system for specific appointments; and

6. The use of Sign Video facilities in all GHA departments (including the PALS Office).

Investigation and Findings

Ombudsman note: *[The CHS was established in April 2015 as an independent complaints mechanism for the sole purpose of accepting, investigating and resolving complaints filed by service users against the GHA. The CHS enjoys an arms-length agreement with the Office of the Gibraltar Public Services Ombudsman whereby in the event that complaints cannot be resolved at first instance, the Ombudsman has a discretionary power in law to accept the transfer of a specific complaint, with the complainant's prior consent in writing].*

The CHS presented the complaint to the GHA in writing setting out the facts as alleged by the Complainant and requesting their comments.

A reply was received by the A&E Lead clinician ("LC"). In the first instance he thanked the CHS for forwarding the complaint. He further explained that A&E did not currently benefit from use of the Sign Video facility for deaf patients. He agreed that it *"would be a useful service to have."* He stated that A&E did not control their department's budget and the set-up of the service would have to be approved by the GHA's Chief Executive Officer and Management.

In conclusion to his reply, the LC stated that he was sorry to hear of the Doctor's perceived body language but was *"sure that is was unintended because it would be way out of his character."*

The CHS issued a further letter to thank the LC for his statement on the provision of the Sign Video facility at A&E and stated that they would raise the matter with GHA Management. In relation to his comments on the Doctor's perceived behaviour, however, they requested a written statement from the Doctor concerned in reply to the Complainant's allegations. The LC was informed that the CHS was also seeking two statements from nurses who had allegedly witnessed the events.

A statement from the Doctor concerned followed:

He recalled how the consultation related to an illness of a child. The Doctor stated how he commenced his consultation by introducing himself to all present and then enquiring about the background of the condition that had brought the child to A&E. According to the Doctor, as the child was of an age where he could answer for himself and indeed, was the one feeling the symptoms, he began his enquiries with him. The doctor informed the CHS that whilst querying the child, the mother (Service User) *"seemed not to like that [I] was talking to him and kept cutting him off and interrupting his narrative. I did raise my hand to indicate to her to allow the child to continue, but*

under no circumstance did I put my hand within one foot of her face. Indeed, I was sitting in my desk chair and [the Service User] was standing closer to the door which was more akin to a metre away."

The Doctor further stated that when the Service User spoke, she expressed symptoms that the child was not describing and that, caused further confusion. Accordingly, he felt that there existed a risk of misdiagnosis and all the more, wanted to hear the child's side of the story. *"I just felt that this sharp child did not need to be stopped from expressing his symptoms."* In addition, he expressed his apologies in his statement to the Service User for his *"attitude"* and her perceived interpretation that he *"did not put importance into what she was going to say. I would have asked her anyway after the child had finished his side of the story."*

The statement was concluded by the Doctor openly stating that he did understand that having a hand raised may have been perceived as unpleasant but that it was not her intention to humiliate her. *"My intentions were good but my method was wrong. I do recognise that. My apologies."*

The two nurses' statements were also made available by the GHA to the CHS. The first stated that she had no involvement in the matter and offered no comments. The second nurse did state that although he did not enter the consultation room with the service users, *"they did look distressed and were not happy with the treatment they had received from the A&E Doctor."* As a result the nurse tried to diffuse the situation with the outcome that another doctor also examined the child.

The nurse went on to state that later that day, the Service User said he was unhappy with the treatment received and would be making a complaint at a higher level. The nurse's response was that he could of course complain if he was dissatisfied with the treatment received as he [as a nurse] *"treated any patient or relative with the utmost respect."*

Given the nature of this complaint, the CHS transferred the investigation to the Office of the Ombudsman.

The Ombudsman reviewed the file and correspondence and made additional enquiries in relation to UK standards applied vis-a-vis NHS provision for deaf patients/ service users. The Ombudsman also considered two examples of similar complaints brought before the Scottish Ombudsman ("SPSO").

In the first case, the complainant raised concerns about the failure of an NHS Trust to provide a British Sign language (BSL) interpreter for a patient in hospital. The complaint was investigated with the finding that an interpreter should have been provided.

The second complainant's circumstances were very similar in nature. The complainant was profoundly deaf and had been in hospital for three days without a BSL interpreter. The NHS Board failed to secure one and asked the family to do so. Upon review, the Board subsequently agreed that it was their responsibility and not the family's, to secure interpreter services. SPSO upheld the Board's decision.

The Ombudsman has also perused Guidelines (currently at the consultation stage) issued by the Scottish Parliament (to be followed by medical trusts). These include *inter alia:*

(1) the translation of screening and immunisation programmes into BSL;

(2) the improvement of access to, and the availability of, professionally approved health information on BSL by ensuring that it is located in a central place online; and

(3) the development of BSL awareness training for health and social care staff ensuring that it is readily accessible at the point of need and tailored to a health setting.

Recommendations and Outcome

The Ombudsman considered this to be a straightforward complaint on which to deliver his findings.

The Complainant had made a complaint on behalf of the Service Users who could not properly communicate with a healthcare professional whilst their young son was being examined by a GP, as a result of failings in Sign Video Facilities.

The Ombudsman noted the comments made by the LC in relation to the non- existence of the service at A&E. He would therefore be making recommendations to the GHA and HM Government of Gibraltar for the potential improvement of the service, based upon but not limited to, the stance adopted by the Scottish Parliament.

Insofar as the complaint relating to the A&E Doctors perceived behaviour towards the Service Users at the consultation was concerned, the Ombudsman duly noted his statement providing an explanation and apology. In the circumstances, the Ombudsman upheld that limb of the complaint with no further recommendations to be made.

Classification

That the Doctors behaviour was not in keeping with good practice and was perceived as "humiliating": **Sustained**

No recommendations made. The Ombudsman considered that the apology offered was reasonable and transparent.

In respect to the Complaint that suitable procedures be adopted for deaf service users with appropriate training for medical staff: **Sustained**

Recommendations

1. That Sign Video facilities or an appropriate BSL approved mechanism be implemented within the GHA;

2. The development of BSL Training and awareness for healthcare and social staff and ensuring that facilities are accessible and operative;

3. That the GHA produce protocol guidance to staff and provide further training where appropriate on deaf culture, language and legal rights;

Note: A sign Video facility has now been set up at St Bernard's Hospital A&E Department.

Gibraltar Health Authority

Case 4

Background

Complaints:

(i) The Complainant was unhappy about the treatment received at the Gibraltar Health Authority's ("GHA") Accident & Emergency ("A&E"), which resulted in him having to be transferred to a hospital in the UK upon his arrival in the United Kingdom ("UK"), hours after his attendance at A&E where he had been advised that there was be no problem for him to fly; and

(ii) The Complainant was aggrieved because no assistance had been provided by the GHA's Sponsored Patients Department ("the SPD") in respect of his return to Gibraltar, after his discharge from a hospital in the UK.

On the 13th November 2016, just hours before he was due to fly to the UK, the Complainant had to attend A&E because he had been urinating blood. Whilst at A&E, the Complainant was asked to pass urine and in so doing he felt some unease. Both the nurse and the A&E doctor who attended to the Complainant advised him that this could have been a kidney stone.

According to the Complainant, the doctor did not undertake any tests on him but instead checked his blood test results, which dated back a couple of months. The doctor then advised him that he saw no problem with him flying and that he should go to the UK and enjoy himself. The Complainant asked the doctor for a letter which he could take with him to the UK in case he required medical attention and the doctor provided him with this accordingly.

Twenty minutes after boarding the plane, the Complainant suffered an excruciating pain on the right kidney which continued throughout the duration of the three-hour flight to the UK and this ended with him having to be transferred to a hospital by ambulance shortly after landing.

According to the Complainant, numerous tests were immediately carried out at the UK hospital and within hours he was sent for a CT scan. In the space of twenty four hours he was diagnosed with having a very large cancerous tumour on the right kidney.

The Complainant was also aggrieved because, prior to being discharged from the UK hospital, the SPD informed him that he would have to make his own arrangements for his flight back to Gibraltar. The reason given was that he had flown to the UK of his own accord and the SPD would therefore not be able to assist him further until he returned to Gibraltar.

Investigation & Findings

Complaint (i)

The Ombudsman sought clinical advice on this case from an independent medical adviser, an Emergency Medicine Consultant ("the Clinical Adviser"). The Clinical Adviser concluded that the main issue stemmed from the A&E doctor having failed to appreciate that gross haematuria (blood in urine) is associated with clot retention and thereby not having provided appropriate advice.

Had the A&E doctor known this, he could have advised the Complainant that before taking his flight to the UK, he should have ensured that he could pass urine and had no pain or urinary symptoms. The risk of running into problems on a short haul flight would then have been less.

The Clinical Adviser pointed out that, although a urine dip-stick test and examination had been undertaken by the A&E doctor in keeping with good practice, the following fairly basic tests should also have been performed:

- A urine sample should have gone to the laboratory for culture and sensitivity to exclude infection as the cause of haematuria;
- A full blood count should have been sent to evaluate the presence of any anaemia and if the white cell count was raised it would have supported the diagnosis of infection;
- Coagulation studies should have been requested to identify if there was an undiagnosed coagulopathy (a condition in which the blood's ability to coagulate (form clots) is impaired);
- The Complainant's electrolytes should have been requested to identify if there was any renal damage, either causing the haematuria or as a result of this.

With regard to the Complainant's statement that the A&E doctor had checked the results of blood tests, which had been carried out weeks earlier, the Clinical Adviser confirmed those would not have been relevant to his assessment at A&E other than to serve as a comparison had new samples been taken on the day of his attendance at A&E.

According to the Clinical Adviser, gross haematuria, even when transient and painless, may indicate a significant disease process and always requires further investigation; it is a usual sign in more than 66% of patients with urological cancer. Patients with gross haematuria represent a higher risk group than those presenting with microscopic haematuria. The Complainant was 50 years old at the time and painless gross haematuria should have alerted the A&E doctor to the possibility of a significant risk for cancer.

On the 7th December 2016, the Complainant underwent a successful procedure for the removal of the tumour at a tertiary referral unit.

Complaint (ii)

The SPD do not become involved in cases where persons are taken ill or admitted to hospital whilst abroad. Their remit was limited to making the arrangements for GHA patients referred by a GHA consultant to a tertiary referral unit outside Gibraltar. Notwithstanding this, a staff member of the SPD had actually assisted the Complainant by providing him with advice on the best way forward

and by giving the Complainant contact numbers for the Medical Director and GHA Consultant in case he or the hospital needed to contact the GHA.

Recommendations and Outcome

Complaint (i)

The Ombudsman sustained this complaint and recommended that A&E staff should learn from this case in order to avoid a recurrence of a similar situation. A&E protocols should be reviewed by GHA management to include the basic tests that should be performed on patients with haematuria.

Complaint (ii)

The Ombudsman did not sustain this complaint. The Complainant had travelled to the UK in a private capacity and not as a GHA sponsored patient. The SDP had adhered to the parameters of their remit but had nevertheless assisted the Complainant where possible.

Gibraltar Health Authority

Case 5

Background

The Complainant was aggrieved because, despite recommendations from various medical specialists at the Gibraltar Health Authority ("GHA"), funding had been refused for a cosmetic surgical procedure.

The Complainant claimed that as she was suffering from psychological issues because of the cosmetic aspect of her breasts, she had been referred by the General Practitioner ("GP") at the GHA's Primary Care Centre ("PCC") to one of the GHA's visiting plastic surgeons ("the Surgeon").

The Surgeon informed her she would have to go through a process in order to qualify for cosmetic surgery, as each case was assessed individually. As part of this process, the Surgeon arranged to refer her to the GHA's psychologist ("Psychologist"). The Complainant complied with this and in mid-2015 she was informed by the Surgeon that he would put her case to GHA management and place her on a waiting list.

With no developments by January 2016, the Complainant visited the GHA's St Bernard's Hospital for an update and, by chance, met the Cancer Care Coordinator ("CCC") who advised her that she would make enquiries. In March 2016 the Complainant contacted the CCC who told her she would contact the GHA's Chief Executive ("CE") in order to approve the funding and would book an appointment with the Surgeon for the procedure to be undertaken. Hours later, the Complainant claimed that the CCC contacted her and informed her that the CE had refused that funding because it was GHA policy not to fund cosmetic surgery procedures other than in cases of reconstruction in respect of cancer patients. The Complainant was devastated by the news, not least because she had already undergone the qualifying process and none of the medical professionals involved in her case had ever mentioned the GHA's policy on the requirements for the funding of cosmetic surgery.

Investigation & Findings

The Ombudsman's investigation found that new guidelines for plastic surgery were adopted by the GHA in 2012 in order to make a distinction between patients where the surgery was for purely cosmetic reasons and those that required surgery on medical grounds. From then on, the GHA requested the two visiting plastic surgeons to differentiate between these two groups. A decision was also made at that time for patients who were already on the waiting list to have their surgery honoured, even where some of the procedures required were purely cosmetic. However, after that cut off point, patients would only be included on the waiting list on medical grounds and then only in cases involving physical medical issues not psychological ones.

In the Complainant's case, in May 2015 the Surgeon wrote to the GHA's Medical Director ("MD") setting out the Complainant's situation and the fact that the procedure was supported by the Psychologist *"...on psychological grounds"* but no written response to that letter was available in the Complainant's medical file.

Recommendations and Outcome

The Ombudsman found that there had been maladministration in this case on the part of the MD in not having submitted a timely response to the Surgeon's request. This had resulted in the Complainant's case being 'suspended' within the system and her having to chase the matter, especially because the Surgeon was not based in Gibraltar. A timely response by the MD to the Surgeon could have enabled the GHA's decision to be conveyed to the Complainant some nine months earlier.

The investigation also found that GHA medical staff who had dealt with the Complainant's case appeared not to have been aware of the revised cosmetic surgery funding guidelines that were in place since 2012.

The Ombudsman sustained the complaint on the basis that:

(i) The Complainant was never informed of the change in GHA policy guidelines regarding the funding of cosmetic surgery. She was made to go through an unnecessary qualifying process after which the surgical procedure that she had been promised was refused on policy grounds;

(ii) The GHA doctors and other staff who attended to the Complainant appeared to be unaware of the GHA's revised funding guidelines in relation to cosmetic surgery; and

(iii) Accurate and timely records were not made in the Complainant's medical file, which contributed to the delay in addressing the matter and in communicating the decision regarding the surgery to the Complainant.

The Ombudsman recommended that the GHA should ensure that all relevant staff is kept fully apprised at all times of any changes in GHA funding guidelines and policy on surgical and other treatment, in order to avoid a recurrence in similar cases. In this particular case, the GHA should, at the very least, consider giving the Complainant an apology.

Gibraltar Health Authority

Case 6

Background

A woman ("the Complainant") complained about the treatment that her young son ("the Patient") had received from the Gibraltar Health Authority ("GHA"). The Patient had suffered from a variety of congenital birth defects and had required treatment and hospitalisation both in Gibraltar and abroad. The Complainant was aggrieved by the alleged lack of healthcare management received from the GHA, primarily in relation to lack of communication concerning medical reports and results and with the apparent disorganisation relating to healthcare appointments in the United Kingdom.

Investigation & Findings

The Ombudsman received full and frank replies from the GHA in answer to the issues raised in his investigation. He found that in many cases, where appointments had been made for patients in a number of hospitals abroad, the medical reports from one hospital were not available at the time of the patient's appointment at another hospital.

The Ombudsman also found that it was not uncommon for medical practitioners at the GHA to have to ask the patients themselves, or in this case the parents of the patient, about the outcome of their medical examinations upon their return from the tertiary hospitals abroad.

Recommendations and Outcome

The Ombudsman was of the view that the GHA had an overall and ultimate duty of care for all their patients, including those patients who were sent by the GHA for treatment to tertiary hospitals abroad. The Ombudsman recommended that proactive steps be taken by the GHA to devise a system to alleviate the practical issues raised by this complaint.

The Ombudsman was pleased to note the comments received from the GHA's Medical Director, which confirmed that an IT system was being put in place by the GHA in order to help mitigate these healthcare management and communication issues.

The Ombudsman thanked the Complainant for highlighting this matter. The complaint has contributed to the improvement of the service being delivered by the GHA for the benefit of future patients who are referred to tertiary hospitals abroad.

Gibraltar Health Authority

Case 7

Background

The Complainant was aggrieved by the fact that despite having received weekly acupuncture sessions from the Gibraltar Health Authority ("GHA"), which greatly alleviated his severe Fibromyalgia, the acupuncture was stopped without warning or notice.

[Ombudsman Note: The background is mainly based on the version of events provided by the Complainant, including supporting documentation, at the time of lodging the Complaint with the Ombudsman]

The Complainant explained that he had been a GHA patient for the last fifteen years. As a direct consequence of having contracted the Varicella disease as an adult, he was now suffering from Fibromyalgia which included chronic fatigue and migraine. He had been sent by the GHA to a tertiary referral unit in Spain for treatment. This treatment consisted of tri-annual Botox injections, which alleviated his pain. He further stated that he had no complaints whatsoever against the GHA (Pain Clinic) since he had been treated extremely well there.

The Complainant explained that, as part of the process towards rehabilitation at the Pain Clinic, he was also receiving excellent treatment from the Physiotherapy Department ("Physiotherapy") where, amongst other things, he was being administered acupuncture treatment once a week. He explained that for a person who lived with acute pain, the acupuncture treatment had been highly beneficial and relieving.

The Complainant explained that on the 18th November 2015 (whilst attending Physio for acupuncture treatment), he was informed that he would no longer receive acupuncture sessions through the GHA. He stated that members of staff were not in a position to comment as to why that decision had been taken. The Complainant further explained that whereas in the past he had received acupuncture privately, he would no longer be able afford that option since he had been off work on sick leave for almost a year.

The Complainant was concerned and aggrieved by the position adopted by the GHA. He questioned how the acupuncture sessions could have been stopped without prior consultation with his doctors, physiotherapists and indeed himself, with no suitable alternative having been provided thereby eventually leaving him in pain.

Investigation & Findings

The head of the GHA's Primary Care Centre ("Head of PCC") informed the Ombudsman that staff at Physiotherapy had been trained in the use of acupuncture and that they had submitted a proposal for the GHA to allow acupuncture treatment as a modality for patients suffering from lower back pain. He further stated that staff at Physiotherapy had misunderstood the fact that formal approval by the GHA board ("the Board") for the provision of acupuncture treatment was not a mere formality, as they had understood this to be, but that such approval was a necessary requirement.

The Head of PCC confirmed that staff at Physiotherapy had mistakenly commenced providing acupuncture treatment **before** the Board had approved this. According to the Head of PCC, a situation was thereby created whereby should harm have been caused to a patient, the practitioner would have potentially not been covered by the GHA's Indemnity Insurance policy. Arising from that concern, staff at Physiotherapy were instructed to temporarily stop practising acupuncture until its usage had been formally approved by the Board. This was subsequently presented for approval by the Board on the 8th December 2015 and was ratified by the Chairman. However, approval by the Board was given for the use of the modality in relation **to back pain only** from the date of ratification (*as had been presented* to the Board *for approval*).

The Head of PCC confirmed that on the basis that the Complainant had already been receiving acupuncture for lower back pain, the Complainant would be allowed to resume his treatment (which he did for six further sessions).

Arising from the complaint, the CEO of the GHA ("CEO") commissioned an investigation panel ("the Investigation Panel") to conduct an internal investigation into the alleged unauthorised provision of acupuncture treatment by clinicians.

The Ombudsman noted that a formal disciplinary procedure had also been commenced against the Head of Physiotherapy ("HP") for "*Commencing an acupuncture service without approval of the Line Manager or the Minister.*"

The HP informed the Ombudsman that on the 12th November 2015 the CEO had informed her that Physiotherapy were working without an approved acupuncture policy and without authorisation from the Head of PCC. As a result, therefore, all patient appointments should be cancelled because approval to commence, what was referred to as an "*Acupuncture Service*", had not been granted by the GHA. Consequently, all appointments were cancelled immediately. It was not until the 10th December 2015 that the 'acupuncture policy' was agreed by the CEO and **only for spinal patients**.

HP explained to the Ombudsman that ten GHA Physiotherapists and a general practitioner had attended a two weekend (totalling six days) course in MSK Western Acupuncture as a Physiotherapy Modality in April/May 2015, with completion of their case studies in July 2015. The course had been agreed by both the CEO and the Head of the PCC and the cost of this course had been funded by the GHA. The course was delivered by the Senior Tutor/Chairman of the Acupuncture Society of UK Chartered Physiotherapists.

According to the HP, the qualification fell within the locally registered Physiotherapists' scope of practice and therefore provided them with the required GHA Indemnity cover for malpractice. She also added that no complaints whatsoever had been received by any patient in relation to the treatment being offered- "*quite the contrary, there have been substantial benefits, with [the Complainant] reporting significant improvement.*"

In her written statement to the Ombudsman the HP also mentioned that for the purpose of training, an acupuncture policy was required in order to ensure that staff at Physiotherapy had all the health and safety and other requirements parameters in place. She mentioned that this acupuncture policy had been approved by the course lecturer and that this had been offered to the Head of PCC on completion of their training on the 23rd July 2015 for presentation to the Board and for formal ratification thereof. The HP pointed out that, although this would not normally have been a GHA requirement, the acupuncture policy was offered to the Head of PCC in line with what was considered by Physiotherapy to be best practice.

The statement from the HP further confirmed that the first opportunity to present the acupuncture policy to the Board for ratification, for which purpose the HP had been given an appointment by the Head of PCC, was on the 10th November 2015. That appointment was cancelled by the CEO on the 9th November 2015, as the Head of PCC had not given him notice of it and the appointment was deferred until 8th December 2015.

The Investigation Panel took a considerable amount of time to compile their evidence and publish their findings. In their report they highlighted the issue of delay and attributed this to a lack of GHA secretarial support, recommending that such support be provided in future to ensure efficiency and reasonableness in the delivery of findings.

The Ombudsman would like to formally thank the CEO for making the Investigation Panel's report available to him as soon as he was in a position to release it.

The Ombudsman noted that the Investigation Panel had interviewed the Head of PCC, the HP, the HP's Deputy and Lead Senior Physiotherapist and two other relevant staff members. The following useful chronology was presented:

- May 2014: Minister for Health announces acupuncture is to be offered by the GHA;
- February 2015: Lower Back Pain Policy presented to the Board (steering group asked to forward policy to CEO with some changes) - policy approved;
- April 2015: Acupuncture Policy drafted and forwarded to the accredited tutor;
- May 2015: Commencement of Acupuncture training;
- April to August 2015: Patients seen [for acupuncture treatment at GHA] as part of the training;
- October 2015: Staff successfully complete training and are fully competent to pursue acupuncture as a physiotherapy modality;
- 12 November 2015: Conversation between the CEO and HP - to stop Acupuncture Service until formal approval by the Senior Executive;
- 13 November 2015: Senior Physiotherapists informed by HP that Acupuncture is to cease, pending an investigation;
- 8 December 2015: Acupuncture Spinal Policy approved by the Senior Management Team.

Without wishing to delve into the detail of the internal investigation, the Ombudsman noted the Investigation Panel's observations in relation to the question of whether there were any failings by Physiotherapy in following GHA procedures and good governance. Statements from Physiotherapy indicated and corroborated that staff assumed that once training had been completed, in line with other courses that they had undertaken in the past, the modality in question was to be adopted and used. The Panel concluded that there had been "*no intentional wrongdoing by the physiotherapy staff and they continued practising acupuncture once accredited, with the sole aim of improving the well-being of the patients they treated by offering an additional modality within their scope of practice.*

Staff continued treating patients beyond the period of training, and booking new patients for acupuncture, without malice or a hidden agenda".

They also found that "*there [was] no evidence to suggest that patients or staff were placed at risk as a result of patients being treated with acupuncture. Staff are fully competent in order to carry out acupuncture with their scope of practice and they are covered for medical malpractice.*"

Significantly, it was determined that if the delivery of acupuncture treatment was subject to the formal approval by the Board of a policy, that should have been clearly communicated to staff from the outset by the Head of PCC. There was no evidence that this had occurred and staff therefore assumed that once trained in the modality in question, that acupuncture treatment could be offered by them.

In its recommendations the Panel took note that Physiotherapy staff did not purposely initiate a service but simply adopted the use of acupuncture as another modality available to them when treating patients with lower back pain. On that basis, they recommended that no action be taken against Physiotherapy staff. They also felt that there should not have been the need to carry out a formal investigation into the matter. A meeting with all stakeholders concerned would, in their view, have sufficed in order to clarify issues.

Recommendations and Outcome

The Ombudsman was grateful to the Head of PCC and in particular to the HP, the latter having provided a full account of the facts which greatly assisted the Ombudsman in the conduct of his investigation. Additionally, the prompt and open cooperation of the CEO, especially in the provision of the Investigation Panel's findings, proved invaluable to the Ombudsman in this case.

The Ombudsman concluded that despite GHA Senior Management seemingly appearing to have wanted to disassociate itself from the actions of Physiotherapy, the GHA as an organisation was responsible for the provision and subsequent cessation of acupuncture treatment as a physiotherapy modality. Despite noting the CEO's position that the service was not "*GHA approved*" it was nonetheless conducted by GHA staff, within GHA premises and during the hospital's ordinary working hours and course of business. Further to the Panel's investigation, it was determined that the Physiotherapy staff were acting *bona fide* and that the suspension/cessation of the service arose as a result of them not having received clear instructions from management.

The fact remains that in providing a service which was subsequently stopped without any notice to the Complainant (and indeed to other patients) and without having offered any explanation for the cessation or an alternative avenue for therapy, the GHA as an institution failed the Complainant both administratively and in their duty of care towards him.

Gibraltar Electricity Authority

Case 8

Background

Following the amendment to the Limitation Act on 27th July 2016, proceedings for the recovery of any debt owed to the Crown (which includes the Gibraltar Electricity Authority) are no longer time-barred. Previously, there was a limitation period of 6 years for such debts and any outstanding electricity bills were statute-barred and no longer followed up.

On 20th July 2016 (even before the commencement of the amendment to the Limitation Act) the Complainant, was sent a letter by the Gibraltar Electricity Authority ("the Authority"), claiming that arrears amounting to £518.42 were due by him. This amount related to an old electricity account that had remained inactive for over 22 years. The Authority threatened the Complainant with disconnection of the electricity supply to his current home and to his current business premises and furthermore, reserved their right to refuse to supply him with electricity at any future address, unless the historic debt was settled by him within 21 days of the date of the letter.

The Authority were, however, not in a position to provide him with any details of their claim against him other than a printout showing the date and amount of the debt, as reflected in their computer system. In particular, the Complainant had requested further details on an entry of £442.50 dated 6th May 1994, which appeared from the print-out to refer to an 'invoice' rather than to a monthly electricity bill, suggesting that the entry did not actually relate to monthly electricity consumption. The Authority were unable to provide him with any further details due to the fact that the data in their computer system had been 'migrated' a number of times over the years and the only information available was a 'print screen' of the 'transaction report' of such historic accounts, showing the amount and the dates of aged transactions. Copies of individual bills on such historic inactive accounts were not retained and were no longer available to the Authority.

Notwithstanding the above, in order to prevent the electricity supply being cut off to his home and business premises, the Complainant was left with no option but to settle the amount being demanded from him. He subsequently lodged his complaint with the Ombudsman.

Investigation and Findings

The Ombudsman was of the view that it cannot be the intention of the Government that the Authority should impose such unreasonable and unfair procedures when refusing or discontinuing the supply of electricity to consumers.

Under Section 19 (a) of the Gibraltar Electricity Act, the Authority may, in accordance with the conditions and procedures approved by the Government, refuse to supply or may discontinue to supply electricity to a person whose payment of what is due to the Authority is more than 60 days in arrears.

However, the 'cutting-off' of the supply of electricity to a consumer's home and business premises, on the basis of an historic debt reflected in a computer entry of an inactive account more than 22 years old, and which cannot now be substantiated or backed up by the Authority with any further details or copies of bills or invoices, is clearly quite unfair and unreasonable.

Recommendations and Outcome

The Ombudsman recommended that the Government should issue the Authority with revised conditions and procedures under section 19 (a) of the Gibraltar Electricity Authority Act, in order to prevent further injustices of this type.

Proposed revised conditions and procedures

Following the amendment to the Limitation Act on 27th July 2016, the conditions and procedures to be followed by the Authority when it considers to refuse or discontinue the supply of electricity to consumers because of the non-payment of arrears, should be as follows:

a) *any refusal or discontinuance of supply of electricity should only be considered by the Authority in respect of arrears which are more than 60 days and no more than 6 years old;*

b) *arrears which are more than 6 years old (which prior to the amendment to the Limitation Act would have been statute-barred) should be followed up by the Authority by way of legal proceedings and not by way of a refusal or discontinuance of the supply of electricity.*

In the case of the Complainant in question, the Ombudsman was of the view that the Authority would have found it quite difficult to recover these historic arrears through legal proceedings. The amount reflected as due by this consumer on the inactive account in the Authority's computer system is over 22 years old and the Authority no longer has detailed records of what exactly the debt refers to.

In the circumstances, the Ombudsman also recommended that the Authority should consider giving the Complainant a refund of the £518.42.

The matter is now in the hands of the Chief Secretary.

Ombudsman's Update

The Chief Executive Officer of the Gibraltar Electricity Authority responded to the Ombudsman as follows:

"Following on from the report received from the Office of the Ombudsman, please find below arguments made either in favour or against some of the points raised therein, especially with regards to the recommendations made.

For ease of reference, this reply has been structured in the same way as the original report.

There are two pieces of legislation which are mentioned in the report, these being the Gibraltar Electricity Authority Act 2003 and the Limitation (Amendment) Act 2016.

The Gibraltar Electricity Authority Act 2003, has since it was enacted, enabled/allowed the Gibraltar Electricity Authority ["GEA"] to chase its Customers for settlement of Electricity Arrears. This power was afforded to the GEA through Section 19, and in particular subsection (a) which states:

"The Authority may in accordance with conditions and procedures approved by the Government refuse to supply or may discontinue to supply electricity to – (a) a person whose payment of what is due to the Authority for the supply of electricity or for the supply or the hire of any apparatus or appliance, or for any works or other service carried out by the authority, is more than 60 days in arrears whether such arrears are in respect of the premises to which a supply is to be discontinued or in respect of any other premises but only whilst such payments or charges remain unpaid."

The Limitation Act 1960, defined when a particular debt became statute-barred; i.e. anything over 6 years old. However, this Act did not prevent the GEA from legitimately pursuing Electricity Arrears older than 6 years old, with whatever means at its disposal, including the use of Disconnection of Electricity Supply.

GEA Act 2003 Subsection 19 (a), when combined with the Policy for the Follow-Up of Arrears first issued circa 2005 and which has since been revised as when required, approved by both H.M.

Government of Gibraltar ["H.M. GOG] and the GEA Board, has enabled the GEA to recover a substantial amount of Electricity Arrears, with a considerable amount of debt also tied up in Repayment Agreements.

Although copies of the exact individual Electricity Bills issued at the time cannot be produced, a Statement of Account showing the Electricity Bills outstanding is sufficient evidence for the GEA as to the Electricity consumed and debt incurred.

The statement made whereby the chasing of Electricity Arrears owed in "an inactive account more than 22 years old … is clearly quite unfair and unreasonable" and which then continues to make reference to the Writing-Off procedure, is misleading.

It must be noted that it is not GEA practice to Write-Off any debt on the basis that it is 6 years old or more. The Write-Off's processed in the past, have been carried out in accordance with H.M. GOG procedure, with such Write-Off's being in respect of deceased Customers, Liquidated or Struck Off companies, whereby the GEA Board, following the necessary investigation being carried out, has determined that the respective debt would not be recovered.

The GEA has acted at all times, within its power and in a reasonable manner to recover a debt that was owed to it.

The amendments made to the Limitation Act on the 3rd August 2016, known as the Limitation (Amendment) Act 2016 confers additional powers to the GEA to pursue any debt owed to it through the legal system, regardless of the time elapsed.

The recommendation made in the report to limit the use of discontinuance of Electricity Supply to Customers with accounts that have Electricity Arrears which are more than 6 years old, would represent a severe restriction of the powers of the GEA to legitimately pursue its right to recover its debt. This will impose further hindrance on the GEA which in fact did not exist before the Limitation (Amendment) Act 2016 was enacted. The GEA has used the powers conferred to it within the GEA Act 2003 to discontinue Electricity Supply even when the debts, or part of, were statute-barred.

The GEA feels it is both wrong and unfair to use the Limitation (Amendment) Act 2016, which was enacted to facilitate the recovery of debt, as a trigger to now impose limitations on the GEA's power to recover its debt.

The records kept by the GEA to date, in particular with regards to the complainant, provide the GEA with the satisfaction that the Electricity Supply at the premises was still registered under the complainant's name, and consequently he is liable for any electricity consumed up until the date of Disconnection. Arrangements made by the complainant with the new tenant at the time, are not of GEA's concern, other than ensuring that the Registered Customer settles the monies owed in his name, and consequently, such arrangements should not now be used against the GEA as a way of avoiding the settlement of the Electricity Arrears.

Furthermore, the GEA does not consider there is any merit to the proposal to refund the amount of £518.42 to the complainant because the GEA acted within its power to recover said debt. The debt is legitimate and stands irrespective of not being able to print old Electricity Bills.

The GEA has a right and duty to recover debt by the most efficient and legitimate way possible, irrespective or otherwise of any legal proceedings which the GEA may choose to initiate or enter into.

Burdening the local legal system with claims from the GEA on its Customers for the recovery of Electricity Arrears would be a retrograde step given the power afforded to it within the GEA Act 2003 Section 19; powers which to date, have been used as prescribed within the Act as well as within the Policy for the Follow-Up of Arrears, and which have from time to time, been audited by the Gibraltar Audit Office.

Implications of the Recommendations

The GEA feels that the recommendations made, will ultimately result in the Write-Off of all Electricity Arrears that are prior to the 3rd August 2010, in particular, in those cases where the GEA is unable to produce an exact copy of the individual Electricity Bills, and due to the age of the debt, is no longer able to discontinue the Electricity Supply.

Counterproposal

The GEA considers the proposal made by the Ombudsman, as to when the GEA Act 2003 Section 19 and the Limitation (Amendment) Act 2016 should apply, will only help to hinder the good work which the GEA has achieved to date, and could ultimately result in Electricity Arrears owed in Inactive Accounts never being recovered; i.e. approximately £2.5 million.

It is fundamental, that the GEA Act 2003 Section 19 continues as the main piece of legislation which the GEA follows when recovering Electricity Arrears, and as a result, a counterproposal is made below:

a. Disconnections as a result of Non-Payment of Account, whether on an Active or Inactive Account, continue to be processed as has been the case for the last decade, irrespective of whether the Electricity Arrears owed were statute-barred at the time of enacting the Limitation (Amendment) Act 2016,

b. Electricity Arrears owed on Inactive Accounts, whereby the Customer no longer has an Active Account, but for which the GEA is aware of where he/she is residing, are to be followed up by the GEA by way of legal proceedings."

Following on from the above response from the GEA, and in view that the recommendation by the Ombudsman was that the Government should issue the Authority with revised approved conditions and procedures under section 19 (a) of the Gibraltar Electricity Authority Act in order to prevent further injustices of this type, the Ombudsman wrote to the Chief Secretary, as follows:

"..... I attach the response received from the Gibraltar Electricity Authority ("GEA"). I also attach a copy of the latest draft of my report on this case.

Please note that there is no question that the GEA has acted within its powers under 19 (a) of the Gibraltar Electricity Act. Under Section 19 (a) of the Gibraltar Electricity Act, the Authority may, in accordance with the conditions and procedures approved by the Government, refuse to supply or may discontinue to supply electricity to a person whose payment of what is due to the Authority is more than 60 days in arrears.

The question is whether it is reasonable and proper to apply these procedures in the manner that the Authority has done, especially following the amendment to the Limitation Act on 26th July 2016. It seems clear to me that to threaten to cut off the supply of electricity to a consumer's home and business premises on the basis of a historic debt in an inactive account which is more than 22 years, is clearly not reasonable.

I am sure that it is not the intention of the Government that the Authority should impose such unreasonable and unfair procedures and I would recommend that the Government issue the Authority with revised approved conditions and procedures under section 19 (a) of the Gibraltar Electricity Authority Act in order to prevent further injustices of this type.

The following is an extract of my report on this case:

Recommendations and Outcome

The Ombudsman recommended that the Government should issue the Authority with revised conditions and procedures under section 19 (a) of the Gibraltar Electricity Authority Act, in order to prevent further injustices of this type.

Proposed revised conditions and procedures

Following the amendment to the Limitation Act on 27th July 2016, the conditions and procedures to be followed by the Authority when it considers to refuse or discontinue the supply of electricity to consumers because of the non-payment of arrears, should be as follows:

a) any refusal or discontinuance of supply of electricity should only be considered by the Authority in respect of arrears which more than 60 days and no more than 6 years old;

b) arrears which are more than 6 years old (which prior to the amendment to the Limitation Act would have been statute-barred) should be followed up by the Authority by way of legal proceedings and not by way of the refusal or discontinuance of the supply of electricity.

In the case of the Complainant in question, the Ombudsman was of the view that the Authority would have found it quite difficult to recover these historic arrears through legal proceedings. The amount reflected as due by this consumer on the inactive account in the Authority's computer system is over 22 years old and the Authority no longer has detailed records of what exactly the debt refers to.

In the circumstances, the Ombudsman also recommended that the Authority should consider giving the Complainant a refund of the £518.42.

The matter is now in the hands of the Chief Secretary."

To date, the matter continues to be in the hands of the Chief Secretary.

Housing Authority

Case 9

Background

As a result of mistaken information received by the Housing Authority, the Complainant was removed from the tenancy of the flat in Gibraltar where he has lived, together with his parents, for all of his life.

As soon as the mistake was discovered, the Complainant requested the Housing Authority to regularise the position. The Housing Authority requested the Complainant to provide them with proof of residence in the form of a bank statement, ID card or other such 'proof of residence' document. The Complainant provided the necessary documentation, including his ID card; health card, bank statement, life insurance letters, a copy of Supreme Court jury summons, copy of his entry in the register of electors, and a copy of his car insurance – all these documents showed that his address was, beyond any doubt, the flat in question.

However, despite this required proof having been provided and despite the fact that the Housing Authority agreed that the Complainant meets the full eligibility criteria to be included in his parents tenancy, they have refused to do so on the grounds that he is married to a Spanish national whose main residence is currently in Spain. Although his wife occasionally stays in the flat in Gibraltar, she currently resides in Manilva, Spain, together with her parents, so that she is able to look after her elderly mother.

The Housing Authority claimed that they were following their 'unwritten policy' that both husband and wife were required to reside together in the same flat in Gibraltar before any amendment could be made to the tenancy.

Investigation and Findings

The Ombudsman found that the Complainant had submitted the proof of his residence in Gibraltar, as required by the Housing Authority.

The Ombudsman noted that, had the Complainant remained single, the Housing Authority would have had no problem in including him in the tenancy. However, because he is now married and his wife currently lives in Spain with her elderly parents, the Housing Authority has refused to include him in the tenancy of his flat in Gibraltar.

Recommendations and Outcome

The Ombudsman is of the view that the decision taken by the Housing Authority was clearly unreasonable and unfair and was based on irrelevant grounds. The special family circumstances of this case have not been taken into account.

The Ombudsman referred the matter to the Chief Secretary and requested him to consider the particular circumstances of this case and to see if there was anything that could be done to regularise the position.

HOUSING AUTHORITY

Case 10

Background

The Complainant's 80 year old mother was a tenant of one of the Government housing estates. She had lived there for over 10 years and, as part of her tenancy, had an allocated parking space during that period.

The parking space was withdrawn by the Housing Authority and was allocated to another tenant.

Although the Complainant's mother did not drive, the parking space was being used by the Complainant when he visited and stayed with his mother, who was in need of care due to advanced age and state of health.

A letter from the family's GP had been provided to the Housing Authority, which confirmed his mother's state of ill health and that use of the parking space was required, given the circumstances.

Investigation and Findings

The Ombudsman raised the matter with the Housing Authority. Their reply was that the withdrawal of the parking space had been carried out 'in accordance with Government policy....', which was that parking spaces were to be withdrawn from tenants who did not meet the eligibility criteria – one of which was that they were required to hold a valid driving licence.

The Housing Authority informed the Ombudsman that 'there were several pensioners waiting to be allocated parking bays and the Housing Authority had no other recourse but to insist on the recovery of this parking space'.

The Ombudsman found, however, that the stated policy was not being applied by the Housing Authority consistently and that their procedures were not being applied fairly and evenly to all tenants in the estate.

The Ombudsman found that the Housing Authority had failed to take account of the particular circumstances of the Complainant's mother and that she had, therefore, been treated unfairly.

Recommendations and Outcome

The Ombudsman requested the Housing Authority to ensure that their policies and procedures are followed fairly and reasonably. The Ombudsman pointed out that the particular needs of individuals should be properly taken into account in order to ensure that fairness and common sense prevails in the treatment of our citizens, especially those who are of an advanced age and may be suffering from ill health.

Housing Authority

Case 11

Background

The Complainant, a Gibraltarian national sold her studio flat in Gibraltar in 1998 before she left Gibraltar to reside in Portugal. In June 2015 she returned to Gibraltar with her two daughters, one of whom was severely disabled and in July 2016 she applied for Government housing. This application was made in accordance with the criteria for qualification under the Housing Allocation Scheme ("HAS"), which provided that permanent residence in Gibraltar for one year was required prior to any application.

The Housing Authority, based on the recommendation of the Housing Allocation Committee (HAC) refused her initial application to be placed on the Government housing waiting list. The reason given was that a financial assessment undertaken at the time of the sale of her property showed a positive computation reflecting that she was financially able to afford the monthly mortgage payments at that time and was therefore now not eligible for Government housing.

The Complainant appealed to the Housing Authority against the decision of the HAC. The Housing Authority dismissed the appeal and referred the Complainant to a Government policy introduced in 2005, namely section 5 (d) of the HAS, which reads as follows:

"People who have been home owners and have chosen to sell their homes shall not be entitled to go on the public waiting list unless, in the judgement of the Housing Allocation Committee, the sale was genuinely necessary or there is some justification for being admitted..."

The Complainant was somewhat distressed with the decision and, in December 2016, she lodged a complaint with the Ombudsman. At the time, she also sought assistance from the Government Housing pressure group - Action for Housing.

In March 2017, the Housing Authority informed the Complainant that her application had been thoroughly reviewed and that *'based on the exceptional circumstances of her case, these being her child's disability, it had been agreed to waive Clause 5(d) of the Housing Allocation Scheme.'*

Investigation and Findings

The Ombudsman noted that the application had initially been refused based on the HAC's interpretation of section 5 (d) of the HAS. However, the Ombudsman could not reconcile why the HAC had not taken into account the Complainant's present financial situation as well as and her daughter's disability when considering their initial decision. The HAC had only focused on the Complainant's financial situation in 1998.

The Ombudsman arranged a meeting with the Housing Manager to put across his analysis of the Complainant's case and also to establish the reason why HAC's decision had finally been overturned.

The Housing Manager maintained that the policy in place had been correctly applied by HAC, in accordance with section 5 (d) of HAS, and that the Housing Authority had reviewed the case and agreed to allow the application because of the Complainant's daughter's disability.

Outcome & Recommendations

The Ombudsman found maladministration in this case. The initial application by the Complainant had been refused by the HAC and her subsequent appeal to the Housing Authority had also been refused because of the failure to consider all relevant facts supporting and justifying the application.

The Ombudsman was of the view that the Complainant's circumstances clearly reflected a justification for being admitted to the Government housing waiting list, as envisaged under clause 5(d) of HAS, and that these circumstances had not been taken into account or properly considered by either the HAC or the Housing Authority until the matter was taken by the complainant to the Ombudsman.

The Ombudsman recommended that, when considering applications to the Government housing waiting list in future, the Housing Manager and the HAC should ensure that all relevant facts are brought to the attention of the Housing Authority and that full account is taken, at the earliest opportunity, of any circumstances which could justify the admittance of an applicant to the housing waiting list.

Housing Authority

Case 12

Background

The Complainant was aggrieved because there had been no salt water supply to her Government flat ("the flat") throughout a five-month period.

Ombudsman Note: *This background is based mainly on the version of events provided by the Complainant, including supporting documentation, at the time of lodging the Complaint with the Ombudsman.*

The Complainant claimed that there had been no salt water supply to the flat since late June 2016 (Gibraltar operates a salt water supply flushing system for toilets). The Complainant was aggrieved because the situation had persisted for five months despite her weekly calls of complaint to the Housing Authority's Reporting Office ("the RO").

In November 2016, the Complainant brought her complaint to the Ombudsman.

Investigation and Findings

The Ombudsman followed up the complaint with the Housing Authority and requested copies of the reports made at the RO in relation to the issue. The initial report was dated 4th July 2016 and this recorded that the flat had been without salt water supply for two weeks. The day after that report was made, the Housing Authority's estimators undertook an inspection to identify the source of the problem and to estimate the cost of the works required to reinstate the salt water supply. A works order was then sent by the Housing Works Agency ("HWA") to Gibraltar General Construction Company Limited ("GGCCL").

Ombudsman Note: *GGCCL is a wholly-owned Government company, which is tasked by the Housing Works Agency to undertake such works in public housing stock. GGCCL does this by way of outsourcing to private contractors.*

The Ombudsman sought further details from the HWA who provided the following information:

- 19.10.16
  The works order was returned to the HWA for 're-scoping'. It had been included in a batch together with around one hundred other works orders all requiring re-scoping. HWA advised that they proceeded to undertake that exercise parallel to the processing of new reports;

- 08.11.16
  The works order was re-scoped by the HWA (with a negligible variation being 'fix leaking ¾ inch pipe') and sent back to CGCCL for urgent action;

- 14.11.16
  HWA requested an update and received confirmation from GGCCL that a contractor had been urgently dispatched and arrangements had been made with the Complainant for the commencement of required works;

- 17.11.16
  RO's response to the HWA was that the contractor had informed the Complainant that the salt water pipe was blocked and that they were unable to proceed any further due to the repair being outside their scope of works. The Complainant made a report to that effect and a new works order was generated.

HWA stated that the Complainant should not have been advised that a new works order was required and GGCCL should not have 'disengaged' the contractor from the job. This was because:

(i) The original scope of works already provided for the reinstatement of the salt water supply; and

(ii) It was the established procedure for GGCCL to seek a variation order from HWA to cover any additional work required and to retain the first appointed contractor.

Notwithstanding the above, HWA informed the Ombudsman that they had attempted to proceed with the repairs under the new works order but when they contacted the Complainant to make the necessary arrangements, the Complainant had informed them the works had already been carried out by a private company at the Complainant's own expense.

Regarding the procedure in place at the RO when tenants contact them with complaints of delays in repairs being undertaken, RO explained that they send reminders to either GGCCL or HWA and subsequently relay the responses received to the tenants.

Recommendations and Outcome

It is clear from the findings of the Ombudsman's investigation that the lengthy delay in this case was due to GGCCL as the company took in excess of three months to engage a private contractor to undertake the repairs. They then unnecessarily, according to HWA, returned the works order for re-scoping, which added to the delay.
This case highlights the need to improve the procedures in place at GGCCL. Poor communication between HWA and the Housing Authority has also contributed to delays in the undertaking of repairs with the consequent hardship caused to tenants.

The Ombudsman sustained the complaint against the Housing Authority. The Ombudsman recommended that the Housing Authority should look into and improve the procedures in place in order to ensure that repairs to public housing stock are undertaken in a timely and efficient manner.

Ombudsman's Update

The Housing Authority informed the Ombudsman that since the date of this complaint, all departments involved, namely, Gibraltar General Construction Company Limited, Housing Authority and Housing Works Agency had now established a close, structured working relationship with set deadlines and procedures in place.

Housing Authority

Case 13

Background

The Complainant was a single mother of three children who lived in Government rented accommodation ("her apartment") and was in receipt of social assistance benefits. The monthly house rent for her apartment was £63.54. The Complainant had applied for rent relief to the Housing Authority on a number of occasions but this had been rejected on the grounds that the Housing Authority considered that the Complainant could afford to pay the rental of her apartment from her social assistance benefits.

The Housing Authority was also following up the recovery of arrears of house rent due by the Complainant. Following a meeting between the parties, the Complainant and the Housing Authority were unable to agree to a proposed repayment plan for the recovery of these arrears and the Housing Authority informed the Complainant that they would be following up the recovery of the arrears due in Court.

The Complainant then brought the matter to the attention of the Ombudsman.

Investigations & Findings

The Housing Authority provided the Ombudsman with a copy of the assessment of the Complainant's rent relief application. Also provided were details of the formula used to calculate the rent relief payable, in accordance with the provisions of the Housing (Rent Relief) Rules 2009 ("the Rules"). The Rules set out the rent relief payable as the net difference between (a) the weekly statutory rent, as prescribed by the Rules and (b) 25% of the applicant's household weekly income less an allowance for the persons residing in the household.

The Ombudsman noted that the allowances deductible from the weekly statutory rent under the Rules were as follows:

Married person over 65 years of age	£64.00 per week;
Single person over 65 years of age	£46.00 per week;
Married person under 65 years of age	£57.90 per week; and
Single person under 65 years of age	£36.80 per week.

The Rules currently provide for a further deduction of £0.60 to be made for any children residing in the household. This allowance is not for each child but for the total number of children residing in the household.

The Ombudsman found that the total allowance deductible under the Rules for the Complainant was £57.60 per week in respect of herself as a single mother and just 60p per week for her three children. The Ombudsman was of the view that the allowance for the children seemed somewhat unrealistic and unfair when compared with the allowances deductible for an adult.

The Ombudsman also found that there was an error in the formula as set out in the Rules. The formula prescribed under the Rules is currently as follows:

RR = WSR less ([(GWI x 12/52.2) – A]/4) less £0.60 (where a claim includes children)
(Note: RR is the 'Rent Relief payable per week'; WSR is the 'Weekly Statutory Rent; GWI is the 'Gross Weekly Income'; and A is the Allowance)

The Ombudsman informed the Housing Authority of the error in the formula and pointed out that the correct formula should actually read as follows:

RR = WSR less ([(GMI x 12/52.2) – A]/4) less £0.60 (where a claim includes children)
(Note: GMI is the Gross Monthly Income)

Recommendations and Outcome

The Ombudsman did not find maladministration in this case. The Housing Authority had worked out the Complainant's eligibility to Rent Relief in accordance with the Rules. The Housing Authority had worked this out following the detailed steps set out in the Schedule to the Rules and not by using the erroneous formula prescribed therein.

The Housing Authority had thus determined that, under the present Rules, the Complainant was deemed to be able to afford her current house rent and was not therefore entitled to receive any Rent Relief. The Ombudsman nevertheless advised the Authority that they should arrange for the necessary amendment to Rules in order to make the necessary correction to the formula, as outlined above.

As regards the somewhat low level of allowance that was deductible in respect of children under the Rules, the Ombudsman suggested to the Housing Authority that they should perhaps consider proposing an amendment to the Rules in order to revise this allowance to a fairer and more realistic level.

Health and Safety Inspectorate

Case 14

Background

The Complainant had engaged a firm of professional engineers and building contractors to fix a problem of loose tiles on the roof of her house, where she lived together with her husband. This was one of 13 houses in an estate, all of which had a similar problem of loose tiles on the roof.

Although the Management Company of the estate had received an Abatement Order by the Supreme Court, requiring the company to repair the roof of all 13 houses, they had failed to address the problem in a timely manner.

In the meantime, the Complainant was advised that the failure by the Management Company to effect the necessary repairs would not absolve the individual owners of the houses from any potential public liability claims arising as a result.

The Complainant wanted to minimise any such risk, especially in view that she was in charge of taking care of her husband, who lived with her in the house and who was a vulnerable person with mental health problems. Furthermore, because her husband was under the supervision of the UK's Court of Protection the Complainant was left with little option but to make alternative arrangements to carry out the necessary repairs, as soon as possible.

The Complainant's house was jointly owned with the Complainant's husband. The capital cost of repairs, including the cost of addressing the problem with the loose tiles on the roof, was payable from the moneys held in trust and subject to the prior sanction of the Court of Protection.

The estimate for the capital works required was approved by the Court of Protection. Works on the roof tiles, alongside other works to the property, commenced in accordance with the professional engineer's advice and recommendations and in accordance with the engineer's 'Method Statement' regarding health and safety requirements.

The Complainant's grievance was that shortly after the works to the roof had commenced, a Health and Safety Inspector ("the Inspector") from the Government's Health and Safety Inspectorate visited the premises and had directed that the works be stopped. This was on the basis that, for health and safety reasons, he considered that scaffolding was required for the access to the roof rather than the alternative and more economical option of using rope access. The latter option had been proposed by the Complainant's professional engineers in their Method Statement, as an alternative option that was fully compliant with health and safety requirements.

The Complainant had no option but to comply with the direction given by the Inspector. She obtained the necessary approval from the Court of Protection to incur a further cost of £2,244 for the erection of scaffolding in order to undertake the works required under the Abatement Order.

However, a couple of weeks later, the similar work that was required on the roofs of the remaining 12 houses was carried out, with the approval of the Health and Safety Inspectorate, using the more economical option of rope access rather than scaffolding.

The Complainant felt that the Health and Safety Inspectorate had not followed their procedures fairly by requiring her to incur additional costs on scaffolding whilst approving the more economical and safe rope access solution for the similar works carried out subsequently on the roofs of the other 12 houses in the estate.

Investigation and Findings

The Ombudsman reviewed the evidence provided, including the Engineer's Report and Method Statement and the report from the Health and Safety Inspectorate. Interviews were also carried out with the Inspector and with the Complainant.

The Ombudsman found that the Inspector had insisted on the use of scaffolding for the works to the roof of the Complainant's house on the understanding that these works were more extensive and required more time than the works for the other 12 houses in the estate.

However, the Ombudsman found that this was not the case and that the scaffolding was only required to fix the loose tiles as required under the Abatement Order and that the scope of these works was no different from that required for the remaining 12 houses where the rope access option had subsequently been approved by the same Inspector.

However, the Ombudsman was of the view that the decision taken by the Inspector in insisting on scaffolding for the works to the Complainant's house whilst approving rope access for similar works in the remaining 12 houses, was largely due to a lack of effective communication between the Inspector and the Complainant.

Recommendations and Outcome

Although the Ombudsman considered that there had not been any breach of the law or relevant regulations by the Inspector, in the exercise of his official duties, his actions had clearly resulted in an injustice being suffered by the Complainant.

The Ombudsman considered that allowances do need to be made by public officials when dealing with families where vulnerable persons are involved and where tensions and stresses are usually higher than would otherwise be the case.

When dealing with vulnerable people, especially those with mental health problems, it is even more important for public servants to take the extra time needed, which would otherwise not be necessary, in order to ensure that a full and proper account is taken of all relevant issues.

Due to the particular circumstances of this case, the Ombudsman recommended to the Chief Secretary that Government should consider awarding the Complainant an ex-gratia payment of £2,244 to cover the additional and unnecessary cost incurred.

The Government accepted the Ombudsman's recommendation and the payment was effected accordingly.

Civil Status and Registration Office

Case 15

Background

The Ombudsman received 3 separate individual complaints from the Complainants on the delays that they had been subjected to in relation to their respective Exemption Applications to the Civil Status Registration Office ("CSRO"), under section 12(2) Immigration Asylum and Refugee Act 1962.

Given the factual similarities of these complaints, the Ombudsman considered that the public interest would be best served by way of a systemic report on the matters which gave rise to the grievances.

[Ombudsman Note]: *the background is mainly based on the version of events provided by the Complainant, including supporting documentation, at the time of lodging the complaint with the Ombudsman.*

Complainant 1

Complainant 1 applied for an Exemption Application in October 2014. In April 2015, he passed his test in English language, as was required for the application to be considered.

However, the Complainant stated that, following his application and after having passed his English test, the only feedback he had received from the Civil Status and Registration Office ("CSRO"), whenever he had sought updates, was that he would hear *"next month"*. To the date of filing of his complaint with the Office of the Ombudsman, the Complainant was still awaiting a decision on his application from the CSRO.

According to the Complainant, the delay by the CSRO was having a detrimental effect on his family, as they needed to have the necessary documentation for their children and it was cumbersome and costly for them to obtain such documentation from their country of origin (Romania). The Complainant had two young girls, the youngest having being born in Gibraltar.

Complainant 2

Complainant 2 had submitted her Exemption Application in December 2014. She complained to the Ombudsman because she believed that she was being made to wait an inordinate amount of time for her Exemption Application to be processed and for a decision to be made by the CSRO. She did not understand the reason that had been repeatedly given to her by CSRO that *"applications were considered on their own merits and account was taken of each applicant's personal circumstances and that applications were then submitted for Government consideration."* According to the Complainant, the explanations given by CSRO for their delay could not be justified. This was particularly the case because she had now been living and working in Gibraltar for over eight years. She had also passed her English language test in 2014. In addition, the Complainant had attended Westside Comprehensive School in Gibraltar and was currently employed with the Care Agency. The Complainant's mother and stepfather were also British nationals. She felt, therefore, that there was no valid reason for this inordinate and inexplicable delay with her application.

Complainant 3

Complainant 3 complained of an "*inordinate delay in processing his Exemption Application*". He had also been told by CSRO that applications were dealt with on their own merits and on a 'case by case' basis. The Complainant was of the view that the reasons given for the delay were too general and he was, therefore, seeking a more detailed explanation as to why it should take *"two and a half years for applications to be considered on their individual merits by Government."* The Complainant wanted to know why his application had been deferred and felt he should have been provided with a timescale by CSRO as to how much longer he would have to wait before a decision was made. The CSRO was unable to provide him with an estimated waiting time. The Complainant believed that the CSRO's approach was unfair and unreasonable. The delay was affecting his family life. He needed to "plan his life" as even to be able to visit his family in his country of origin (Poland), he was required to apply for a travel visa, which was both time-consuming and costly.

Complainant 4

Almost three years had elapsed since the Complainant and her husband had applied for Exemption Applications for themselves and their two young boys (their youngest child was a British National as she was born in Gibraltar and thus did not require the Exemption). The Complainant believed that the delay that her family had to endure was inordinate and unjustifiable. The Complainant already possessed a certificate of permanent residence and their English language tests had been passed.

The family had to resubmit their applications on a further two occasions at CSRO's request. This entailed them having to pay for updated police certificates of "good conduct" and having to fill out the extensive application forms three times, one for each family member. The Complainant's latest worry was that in 2018 their existing nationality documentation from their country of origin (Czech Republic) will expire and they would no longer hold any valid documentation. The Complainant just wanted to be told whether the applications to the CSRO had been approved or not so the family could get on with their daily lives in Gibraltar or make alternative arrangements.

In addition, the Complainant had to repeatedly apply for permits to enable her young son to attend school trips in Spain. This, she thought, would have been unnecessary had a decision been made on the application(s).

Investigation and Findings

The Ombudsman wrote individual letters presenting the complaints to CSRO and requesting their comments. After some delay and chaser letters being issued, substantive replies were received in respect of each of the individual applicants towards the end of May 2017, setting out the following:

Complainant 1

The CSRO stated that Complainant 1 had been resident in Gibraltar since 3rd August 2012 and that he had submitted an Exemption Application on the 18th December 2014. He had not met the residency criteria at the time of his application (namely the five years continuous residence requirement prescribed by section 18(1) British Nationality Act 1981), in order to qualify for naturalisation. The Complainant would be eligible to re-apply for exemption once the statutory requirement had been met. According to the CSRO, the position was communicated to the Complainant in a letter dated 16th September 2016 (a copy of the letter was made available to the Ombudsman).

Complainant 2

The Complainant had applied for naturalisation on the grounds of residency on the 18th December 2014. The CSRO commented that after the necessary checks were carried out, the matter had been referred to the Government for consideration but the decision on the application had been deferred. . CSRO explained to the Ombudsman that they would shortly be contacting the Complainant with a view to informing her that her case would be considered at a later date.

Complainant 3

The Complainant had applied for Exemption on the 4th April 2014. CSRO noted that his application had been considered by the Government on two previous occasions and that the decision on the matter had been deferred. The CSRO informed the Ombudsman that in February 2017, the Complainant's application had been re-submitted to the Government for consideration that they were awaiting communication as to whether this had been approved or otherwise. According to CSRO, the Complainant would be informed of the outcome, as soon as it was made known to them.

Complainant 4

Complainant 4 applied for Exemption for herself and her family on the 11th February 2014. The applications had been considered but the decision had been deferred. The applications were re-submitted in February 2017 and are currently under consideration. CSRO confirmed that as soon as any communication was received on the outcome of the applications, they would inform the Complainant accordingly.

Note: At the time of drafting this report, no decision had been communicated to any of the Complainants.

Recommendations and Outcome

The Ombudsman was of the view that there was an unreasonable delay in the procedure for arriving at decisions on such applications. The delays that the Complainants had been compelled to endure were inordinate and unjust. In the Ombudsman's view, this was certainly not in keeping with established principles of good administration, practice or governance. This was further confirmed by the fact that applications had been deferred with no reasons or updates being provided to the Complainants.

In the case of Complainant 1, although the Ombudsman accepted the CSRO's argument that the Complainant had not met the eligibility criteria, the Ombudsman considered it a failing by the CSRO that, despite that fact, the application had been accepted by CSRO in December 2014. An added failing was that it was not until September 2016 (almost two years later) that the Complainant was issued with a letter explaining the position. The CSRO had clearly failed to manage the Complainant's expectations appropriately.
The Ombudsman recommended that a screening process be introduced by the CSRO at the application stage of such applications. This would ensure that applicants actually met the eligibility criteria for Exemption before any forms or documentation were accepted by CSRO counter staff.

The Ombudsman also recommended that, in the interest of fairness, decisions on the applications should be communicated to the Complainants promptly and in those circumstances where an application may have been unsuccessful, full and clear reasons should be provided to the applicant.

Civil Status and Registration Office

Case 16

Background

The Complainant applied for the renewal of his Civil Registration Card ("CRC"), which had an expiry date of 27 November 2016.

The Civil Status and Registration Office ("CSRO") had not renewed the CRC and had offered no explanation as to the reasons for the refusal to do so. The Complainant then wrote to the CSRO on 8th December 2016 seeking a written explanation for the refusal but received no reply from the CSRO.

The Complainant then lodged a complaint with the Ombudsman.

Investigation and Findings

The Ombudsman followed the matter up with the CSRO. On 20th December 2016, he wrote to the CSRO seeking further information on the following:

i) the legal basis for the refusal to renew the CRC; and

ii) the reason why no reply or explanation had been given to the Complainant in this respect.

Over one month elapsed and no reply was forthcoming from the CSRO. The Ombudsman then raised the matter directly with the Chief Secretary on 3rd February 2017.

As a result of the Ombudsman's intervention and with the assistance of the Chief Secretary, the Complainant was issued with his CRC on 13 February 2017.

The Ombudsman noted, however, that no explanation was given to the Complainant or indeed any apology for the delay in issuing the CRC.

Recommendations and Outcome

This was one of a number of complaints received by the Ombudsman against the CSRO regarding their delivery of public services, including the delay in replying to correspondence and not providing explanations or apologies where these have been warranted.

The Ombudsman arranged a meeting with the head of the CSRO to discuss these cases. It became clear that staff at the CSRO, as is indeed the case in a number of other Government Departments, would benefit from some training and awareness on the 'Principles of Good Administration' in the delivery of public services.

With one of the underlying aims of the Ombudsman being the raising of general standards in the delivery of public services, the Ombudsman offered to assist in this regard.

A programme of seminars and other training sessions on the Principles of Good Administration is being arranged by the Ombudsman's Office and the CSRO will be the first Government Department to participate in this programme.

Civil Status and Registration Office

Case 17

Background

The First Complaint related to the complainant applying for British nationality for her two daughters in December 2014, after having sought advice from CSRO on the process. The First Complainant lived in Gibraltar with her husband and daughters and was a British National. The applications for British nationality cost her £144.00. After a period of almost two years the applications had still not been granted.

The Second Complainant also applied for British Nationality in respect of her two daughters in May 2014. She paid £140 for the application process. Almost two and a half years had elapsed and no decision had yet been made by the CSRO.

Investigation and Findings

The Ombudsman raised both complaints with CSRO. It appeared that both Complainants had been ill-advised by CSRO on the procedure to follow. It transpired that the applications should have been made to the UK authorities directly. As a solution, CSRO agreed to reimburse the Complainants. "*Due to the time lapsed in processing the applications, [CSRO] exceptionally agreed to refund the Complainants' fees.*" They were subsequently advised they could submit their applications directly to the UK or re-submit the applications locally for reconsideration at a later date.

The Complainants were of the joint view that, had they been properly advised at the time the applications were made, the nationality issues would have been resolved long ago. The First Complainant stated that "*the whole process to date had been extremely stressful and frustrating to put it mildly*" and that CSRO had been "*inefficient and insensitive*" in dealing with her case.

Recommendations and Outcome

The Ombudsman recommended that CSRO should become fully conversant with the appropriate procedures to follow in applications of this type. Had the Complainants been properly advised at the time and, had they submitted their applications to the UK directly, it was more than likely that they would have achieved finality at a much earlier date. Additionally, a great deal of stress and worry would have been avoided.

Royal Gibraltar Post Office

Case 18

Background

The Complainant complained about the amount of mail that he kept receiving in his home letter box which was not addressed to him. The issue was a long standing grievance which continued to recur. Additionally, the Complainant had received no updates from the Royal Gibraltar Post Office ("RGPO") explaining the action they had taken to alleviate the problem.

[Ombudsman Note]: *the background is mainly based on the version of events provided by the Complainant, including supporting documentation, at the time of lodging the complaint with the Ombudsman.*

The Complainant explained that the issues with which he was aggrieved began to take place in 2012. The Complainant was receiving mail that was not addressed to him and mail that was addressed to him was being delivered to other service users. He stated that since he started receiving mail erroneously he had submitted complaints to the RGPO.

The Complainant provided the Ombudsman with a letter dated 10th October 2016, which he had addressed to RGPO and which had been jointly signed by another service user who had been receiving the Complainant's mail. The letter explained the problem and requested that *"the delivery of mail be carried out professionally and seriously as it merited."* A reply was issued by RGPO approximately two weeks later, stating that the complaint had been forwarded to the Sorting Office Manager ("SOM") who would be in a better position to deal with the issue. Nonetheless, RGPO had requested that the Complainant provide the dates of any erroneous delivery, which would facilitate the task of speaking with the postal workers concerned.

In addition, the Complainant spoke to the RGPO Manager ("the Manager") on the telephone who advised him that the issue was being treated as a serious one.

Since matters did not appear to improve, the Complainant lodged his complaint with the office of the Ombudsman.

Investigation and Findings

The Ombudsman wrote a letter presenting the complaint to RGPO on the 24th January 2016, setting out the Complainant's grievances and requesting RGPO's comments.

RGPO issued the Ombudsman with a reply shortly thereafter, stating that the complaint had been duly noted and that the SOM had been made aware of the problem. The latter had informed the Manager that *"we can only address the mail addressed to [the Complainant] before it leaves the sorting office and ask members of staff to be more careful."*

In response, the Ombudsman thanked the Manager for redirecting the complaint to SOM and further commented that although he (the Ombudsman), was aware that *"the matter was being treated seriously"*, he was also aware of the fact that the Complainant had not been informed that RGPO

could *"only check the mail before it leaves the Sorting Office and ask members of staff to be more careful."*

The Ombudsman commented that since the Complainant continued to receive mail which was not addressed to him, it would be beneficial if, in accordance with the *"Principles of Good Administration"*, the Complainant be contacted to manage his expectations and update him on the position and of any progress made.

At the end of March 2017, the Complainant contacted the Ombudsman to inform him that matters had not improved and that he was receiving mail which was not his, on a daily basis. The Complainant provided the Ombudsman's Office with photographs of a letter addressed to him and delivered to another building and two other items which had been wrongly delivered to his address.

The Ombudsman appreciated the Manager's prompt replies.

The Ombudsman recalled an RGPO site inspection which had been conducted in 2016 on a separate issue. In that instance, the Ombudsman had been apprised of all the processes involved in mail receipt, sorting, dispatch and delivery and the Ombudsman had come the view that RGPO were generally diligent, organised and served Gibraltar well.

However, the Ombudsman concluded that, for the purposes of this complaint, the RGPO had failed the Complainant administratively on an issue which they had been made aware of on numerous occasions.

Recommendations and Outcome

More information and updates should have been provided to the Complainant and insofar as the erroneous deliveries were concerned, these should have reduced substantially in number if not stopped altogether.

Perhaps, having been made aware of the recurring problem, Sorting Office staff should have actually "checked the mail addressed to the Complainant before it left the sorting office" on a periodical basis. Furthermore, given that postmen on that particular run would have been made aware by SOM, of the issue affecting the Complainant, they could have been instructed to ensure that for a limited time, they should check that the recipient's name and address on the item to be delivered corresponded to the Complainant's and not to another service user. In the RGPO's own words, members of staff should have been asked *"to be more careful."*

Classification:

- Complainant not satisfied with the way RGPO dealt with his complaint in relation to wrong delivery of mail- **sustained**; -

- Unhappy with the fact that he kept receiving items of mail which were not addressed to him and mail which was properly addressed to the Complainant, was not appropriately delivered- **sustained.**

Gibraltar Port Authority

Case 19

Background

The Complainant was aggrieved as a result of the alleged mismanagement by the Gibraltar Port Authority ("GPA") in relation to berth allocations and the fees charged for their use.

The Complainant complained that:

1. Numerous requests made by him for his vessel to be reallocated to a larger berth were not properly or adequately considered at the relevant time;

2. Payment of berth fees were unjust as rent was paid according to size of boat and not the size of berth it occupied;

3. Countless boats smaller than the Complainant's boat were now moored in berths larger than the one occupied by his vessel;

4. The Complainant had received no substantive written reply from the Captain of the Port in answer to the issues raised and

5. As a result, the Complainant had to go on a waiting list for a larger berth.

[Ombudsman Note: The background is mainly based on the version of events provided by the Complainant, including supporting documentation, at the time of lodging the Complaint with the Ombudsman]

The Complainant complained that his requests for his vessel to be reallocated to a bigger berth at the new Mid Harbours Small Boats Marina ("MHSBM") remained unanswered at a time when a decision could have been made to accommodate his request. As a result he has now had to join a waiting list for a larger berth to become available. The Complainant also felt that the berth fees were grossly unfair and disproportionate, as payments are calculated according to the length of the boat and not the size of the berth.

The Complainant explained that ever since he had been allocated his berth at the MHSBM in 2016, he had been making enquiries on the possibility of exchanging his small berth for a larger one. The Complainant owns a vessel that "*significantly protruded beyond the finger pontoon*". He alleged that he had contacted a named port officer on numerous occasions and was always told that he "*had not had the time to consider his request*". On the last occasion that the Complainant had telephoned (19th September 2016), the officer informed him that he needed to measure the boat before he could make a decision. By that time all the berths at the marina had been allocated and were already being occupied.

The Complainant explained to the Ombudsman that in December 2016 he noticed that smaller boats than his own were taking up larger berths than the one he occupied. One particular boat, which was

exactly the same make and length as his, was occupying one of the larger berths that the Complainant had requested.

On 23th January 2017, after a period of not having heard back from the port officer, the Complainant wrote to the Captain of the Port ("the Captain") requesting an explanation as to why certain people had been granted larger berths. In his email the Complainant also pointed out that Schedule 3 of the Small Vessels (Moorings Controls) Rules 2016 set out the fees payable in respect of permits granted and that this stipulated that the fees were payable in relation to the hull length of the vessel. The Complainant pointed out that the bigger berths were significantly better in both size and access from the finger pontoons, yet the Rules failed to set the fees on the size of the berth. This, the Complainant felt, was unfair and unjust as he was paying the same fee as the person that had a similar boat as his but who occupied a larger berth.

Following various email exchanges where the Complainant sought information on the criteria and rules for allocation, the Complainant accepted the Captain's offer to meet, in order to discuss the issues raised. However, after the meeting, the Complainant remained dissatisfied and alleged that he had not been provided with satisfactory explanations. Additionally, the Complainant was unhappy with the "*manner and tone*" of his meeting with the Captain.

Further attempts to elicit a reply in writing from the GPA also proved unsuccessful and as a result, he lodged his complaint at the Office of the Ombudsman.

Investigation and Findings

The Ombudsman presented the complaint to the GPA on the 17th May 2017, setting out the Complainant's grievances and requesting their comments.

In their reply, the GPA addressed these complaints numerically as follows:

1. Numerous requests for a change of berth made

It was explained that the Complainant would have been aware that during 2016, the GPA went through a "reallocation of berths" process because they had received many more applications for six metre berths than for eight metre berths and they were keen to make progress towards full capacity during the course of 2016. "*The criteria used for this process was - position on the waiting list, size of boat and an assessment on the strength of interest from the boat owner.*"
"*It was a fluid process against a backdrop of constantly changing information and it is possible that [the Complainant's] requests may have gone unheeded during this phase. Nevertheless he continued to occupy the berth to which he was entitled.*"

2. Payment of berth fees were unjust

"*The payment structure is clearly defined by the Small Vessels (Mooring Controls) Rules 2016, Schedule 3 Part II - Fees payable in respect of permits granted for mooring at MHSBM. It should be noted that [the Complainant] agreed and signed off the fees outlined in the abovementioned rules as a member of the Caretaker Committee. He would also be aware that any future adjustments to the fee structure will need to be managed through the Mid-Harbour Association - Rules 13(5) refers.*"

3. Countless boats smaller than the Complainant's boat are now berthed in areas larger than his

The GPA acknowledged that "some of the bigger berths at the marina had smaller vessels in situ, for the reasons explained in point 1 above."

4. No comprehensive written reply from the Captain of the Port to the complaints set out

"Email correspondence was exchanged in January 2017 and this concluded in a face-to-face meeting on 8th February 2017 with senior management of the Port Authority. During this meeting an offer was made by the Captain to undertake to find a bigger berth for [the Complainant]. This offer was refused as he wanted to choose his own berth. This request was considered unreasonable by senior management and clearly the allocation process could not run on this basis. Senior management felt that there was nothing further to add after this meeting."

[Ombudsman note]- The Complainant disagreed with the version of events that took place at the meeting. He stated to the Ombudsman that it was not the case that he wanted to choose his own berth but that quite simply, after a verbal offer of a berth was made, he asked for it to be followed up in writing. At that point, according to the Complainant, the verbal offer was "*immediately withdrawn.*"

5. Complainant now has to go on a waiting list for a larger berth

According to the reply received by the Ombudsman, the allocation process was now almost complete and there was therefore "*no requirement for a waiting list, for a larger berth.*"
The Ombudsman raised further queries based upon the GPA's reply and consequently, a letter was issued to the GPA on the 6th July 2017. Based upon the Complainant's allegation that he had been in "*continuous telephone contact with the GPA*", the Ombudsman asked how it would have been possible that, as stated by the GPA in their reply, the Complainant's requests "*may have gone unheeded?*" In answer, the Captain stated that his small team had been dealing with "*several hundred berth applicants against a backdrop of constantly shifting information whilst dealing with other responsibilities over a short period of time*". They stated that it was therefore not inconceivable that there may have been isolated cases of miscommunication.

In relation to a query based upon berth allocation and fee structure, the Captain of the Port again stated that the allocation process was "*widely understood*" and that the fee structure was clearly defined in the legislation and that it was linked to "*size of boat not berth.*"

The Ombudsman considered that the GPA's reply to point 3 above was unsatisfactory and a more substantive response was sought. The Captain stated that he was afraid he had "*nothing further to add.*" He did however explain that there was a "*zero sum situation in that any relocation of boats would have a detrimental effect on others. The allocation of berths had been carried out by the GPA staff to the best of their ability, against the information available at the time and on the basis that there was an imperative to proceed with the allocation process.*"

Regarding the alleged offer of a berth at the meeting held between the GPA and the Complainant, the Captain of the Port stated that he made no offer but had stated simply that he "*would look into the possibility of offering a larger berth. When he declined, the matter was closed.*"

The final matter raised by the Ombudsman was a request that the GPA should provide him with details of the policy applicable for those owners who were seeking to reallocate their berth, given that the GPA had confirmed that "*there was no longer a requirement for a waiting list for a larger berth.*"

The reply by the GPA was that the Ombudsman may have "*misinterpreted*" the previous statement. The policy was "*not to relocate current small berth holders (small boat owners) to the larger berths as their entitlement has been met. The reason for this is that there are still several hundred applicants on the waiting list. The aspiration must be to allocate berths to these as they become available.*"

Although the Ombudsman clearly empathised with the Complainant's position and understood his frustration, he was also drawn to the fact that the GPA was conducting a "*large scale operation*" in the allocation of berths at MHSBM and that there were numerous applicants to accommodate within a "*backdrop of constantly shifting information*". Such '*shifting information*' incidentally, was never defined or expanded upon by the GPA in their replies to the Ombudsman.

It was also clear to the Ombudsman that the Complainant was already in possession of a berth and that his entitlement had theoretically been met. Less clear were the different versions of the meeting held between the GPA and the Complainant where the Complainant recalled having been verbally offered a berth with the offer being subsequently withdrawn when requested in writing and, the GPA's version, which was that the Captain had merely offered "*to look into the possibility.*"

The Ombudsman was not in a position to favour one version of events over the other without having been able to review any hard evidence of the said meeting by way of notes and/or minutes, for instance. Be that as it may, that matter was not entirely relevant for the purposes of this complaint. As with all Ombudsman investigations, the main focus of concern was whether the Authority's established policy had been followed and whether there had been an administrative failing.

The Ombudsman's overall view was that despite -

(a) the Complainant's entitlement having been met;

(b) the law having been applied regarding the berth fees; and

(c) the established policy or practice having been adopted in relation to the allocation process;

The facts indicated that the email exchanges and telephone calls between the GPA and the Complainant had created an expectation which was later not met by the GPA. This was exacerbated by the port officer informing the Complainant he would have to measure the vessel in order to take a decision on the reallocation.

The GPA had clearly failed to manage the Complainant's expectations and from that perspective alone, they had failed him administratively.

Recommendations and Outcome

1. Numerous requests made by the Complainant for his vessel to be reallocated to a larger berth were not properly or adequately considered at the relevant time.

Sustained in part. It appeared that although generic GPA reallocation waiting list policy was being followed, the Complainant's expectations should have been properly managed;

2. Payment of berth fees were unjust as rent was paid according to size of boat and not the size of berth it occupied.

Not sustained, since there was relevant legislation in place;

3. Countless boats smaller than the Complainant's were now moored in berths larger than the one occupied by his vessel.

Sustained, as admitted by the GPA;

4. The Complainant had received no substantive written reply from the Captain of the Port in answer to the issues raised.

Sustained, although the Complainant was offered a meeting by the Captain of the Port, which he accepted; and

5. As a result complainant had to go on a waiting list for a larger berth.

Not sustained. It appeared that the need for a relocation list had been dispensed with although the Complainant was not informed of this.

The Ombudsman recommended that the GPA should ensure that applicants' expectations are managed in accordance with the Principles of Good Administration and that the GPA should issue an apology for the delay in addressing the Complainant's issues particularly since, as the GPSA stated, "*his requests may have gone unheeded during the backdrop of constantly changing information.*"

The GPA explained that although there were instances where boats smaller than the Complainant's were moored in larger berths, there had existed a process to appropriately relocate smaller vessels. While that process of allocation was underway and after the Complainant has chosen his small berth form a variety offered to him, the GPA had realised that there existed an increased number of larger berths available than had originally been anticipated, and a shortage of smaller berths. For that reason, applicants, who were being contacted by the GPA as they appeared chronologically on the list, were given the option of choosing larger berths.

Since the Complainant had already chosen his berth, the GPA stated that he would have to wait until the list had been exhausted before he could make a further request for a change.

The Ombudsman recommended that the GPA should write to the Complainant clearly setting out the steps that would be required for the Complainant to reallocate his berth. Despite the Ombudsman accepting the argument, as referred to above, that the waiting list would have to be exhausted before the Complainant berth could be reallocated, the Complainant should be formally notified of that fact.

Driver and Licencing Department

Case 20

Background

This case was first reported in the Ombudsman's Annual Report 2015. Following on from that report and as suggested therein, the Ombudsman reviewed both the current legislation and the possible introduction of an adequate policy to deal with such cases.

The Complainant had purchased a 'personalised number plate' for his daughter as a birthday present when she purchased her new car. The fee paid by the Complainant for the personalised number plate at the time was £200.

The Complainant's daughter had obtained a car loan to fund the purchase of her car. As a consequence of this, both the car and the personalised number plate had been registered in the name of the loan company, solely to provide the loan company with security for the car loan.

When the car loan had been fully repaid by the daughter and upon her request that the personalised number plate be now registered in her name, the Driver and Licencing Department ("the Department") demanded a further fee of £250 for the 'transfer' of the registration of the vehicle and the related personalised number from the loan company to the daughter's name.

Investigation and Findings

Section 6 (3) of the Traffic (Licencing and Regulation) (Personalised Numbers) Regulations, 1985, provides that:

> "If the buyer disposes of the personalised number with the vehicle to which it relates, the person acquiring from the buyer such vehicle with the said personalised number must pay to the Licencing Authority a fee equivalent to the full sum stipulated to be the reserve price prevailing on the date specified in the previous subsection."

The Ombudsman was of the view that the transfer of the registered ownership from the loan company to the buyer upon the repayment of the car loan was not a case of a buyer 'disposing' of the vehicle, as envisaged by the legislation. It was simply a case where the loan company was releasing its security over the car and the related personalised number plate upon the borrower having repaid the car loan in full.

It was clearly unfair for the Department to require the buyer, who had already paid £200 for her personalised number plate, to pay an additional fee of £250 for the same personalised number on the same vehicle.

The Complainant's daughter had initially claimed reimbursement of the £250 additional fee from the loan company, through the Small Claims Court. The claim against the loan company was dismissed by the Registrar of the Supreme Court in accordance with the letter of the legislation. However, in

his Judgement, which was delivered on 8th May 2015, the Registrar of the Supreme Court stated the following:

> "It does seem unfair that where the registration in the name of the loan company is effected simply as security, the purchaser has to pay twice for the same personalised number plate on the same vehicle.....It is a matter for the Licencing Department and Government."

Recommendation and Outcome

The Ombudsman was of the view that the relevant legislation should be interpreted widely in these circumstances in order to avoid such unfairness. It was clearly not the intention under the legislation for a purchaser of a personalised number plate to be required to pay twice for the same personalised number plate on the same vehicle.

In the circumstances, the Ombudsman recommended that the Licencing Department consider making an ex-gratia payment of £250 the Complainant's daughter in order to regularise the position. The Ombudsman referred the matter to both the Head of the Licensing Department and the Chief Secretary so that they could follow up this matter accordingly.

Ombudsman's Update

At a subsequent meeting with the Ombudsman, the Head of the Licensing Authority, informed the Ombudsman that the Department was not minded to make an ex-gratia payment to the Complainant, as recommended by the Ombudsman. However, he would be making arrangements for the Department to display a notice on its premises clearly explaining that, in instances where a vehicle registration bearing a personalised number plate was recorded in the name of a loan company as security, the personalised licence plate holder would have to pay again for the same personalised number plate, upon discharge of their loan.

Additionally, the Head of the Licensing Authority informed the Ombudsman that the major car loan company concerned in this case ("the Company") had agreed that all future hire purchase contracts made between the Company and a vehicle purchaser, would contain a clause clearly explaining that the fee payable for the personalised number plate would have to be paid again upon satisfaction of the loan.

The Ombudsman's 2017 Casebook contains summaries of some of the main cases dealt with by the Ombudsman's Office during the year. Reports on further cases can be found on the Ombudsman's Office Website at www.ombudsman.org.gi.

Ombudsman's Office 2017

Statistics

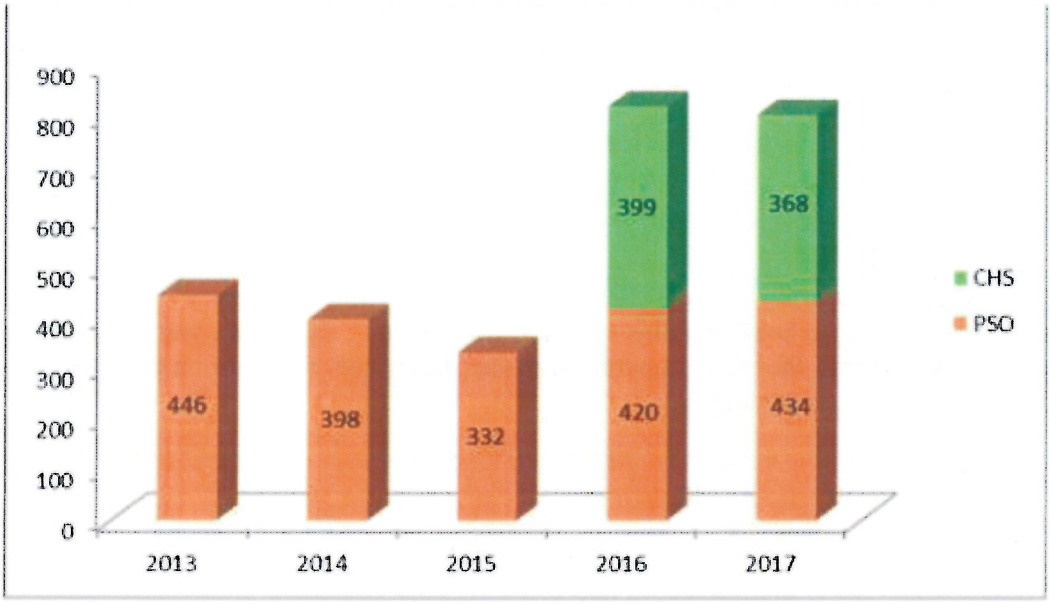
A total of 434 Complaints were received by the Public Services Ombudsman's Office ("PSO") during 2017 and a total of 424 complaints were finalised during the year, as follows:

Complaints not yet finalised - brought forward from 2016	**84**
Complaints received during 2017	**434**
Complaints finalised during the year 2017	**424**
Complaints not yet finalised - carried forward to 2018	**94**

In addition to the above, a total of 368 complaints were received and dealt with directly by the Complaints Handling Scheme ("CHS"), which deals with complaints against Departments of the Gibraltar Health Authority ("GHA").

Complaints received by the Public Services Ombudsman's Office in the last 5 years

Figure 1

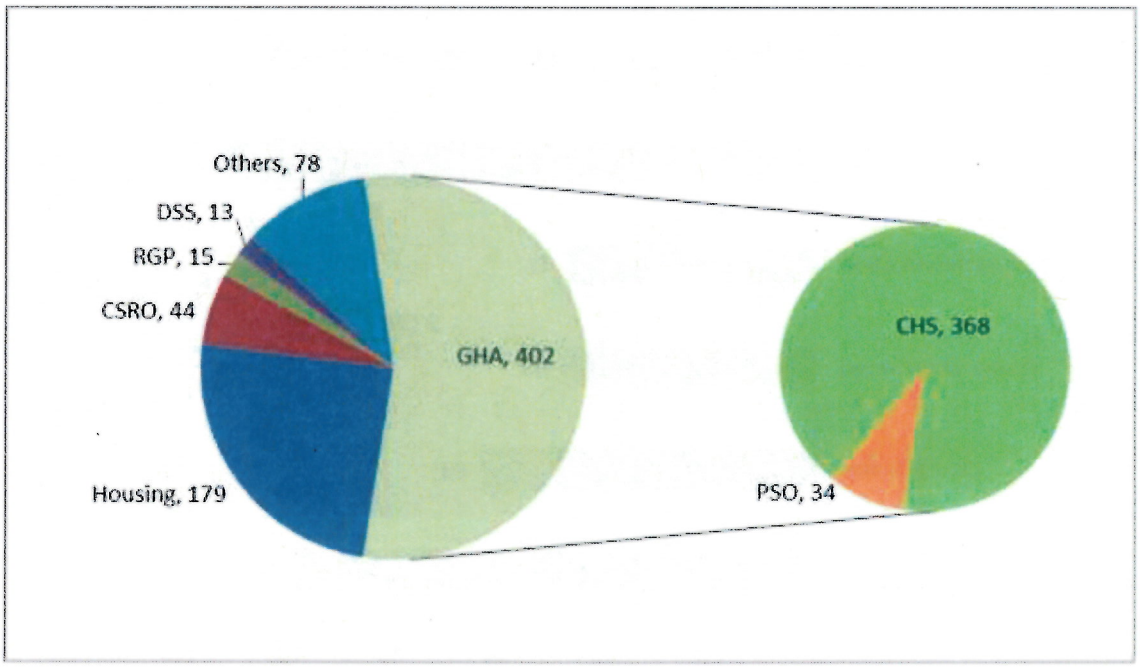


Of the 802 complaints received, a total of 71 complaints were against private entities, which included matters such as private house rents and repairs, consumer-related issues and legal matters that were outside the jurisdiction of the Ombudsman. The remaining 731 complaints received were within the Ombudsman's jurisdiction, as follows:

Gibraltar Health Authority (GHA)	402
Housing Authority (HA)	179
Civil Status and Registration Office (CSRO)	44
Royal Gibraltar Police (RGP)	15
Department of Social Security (DSS)	13
Others	78
TOTAL	731

Complaints received by the Public Services Ombudsman's Office (including the CHS) in 2017 by Public Service Provider

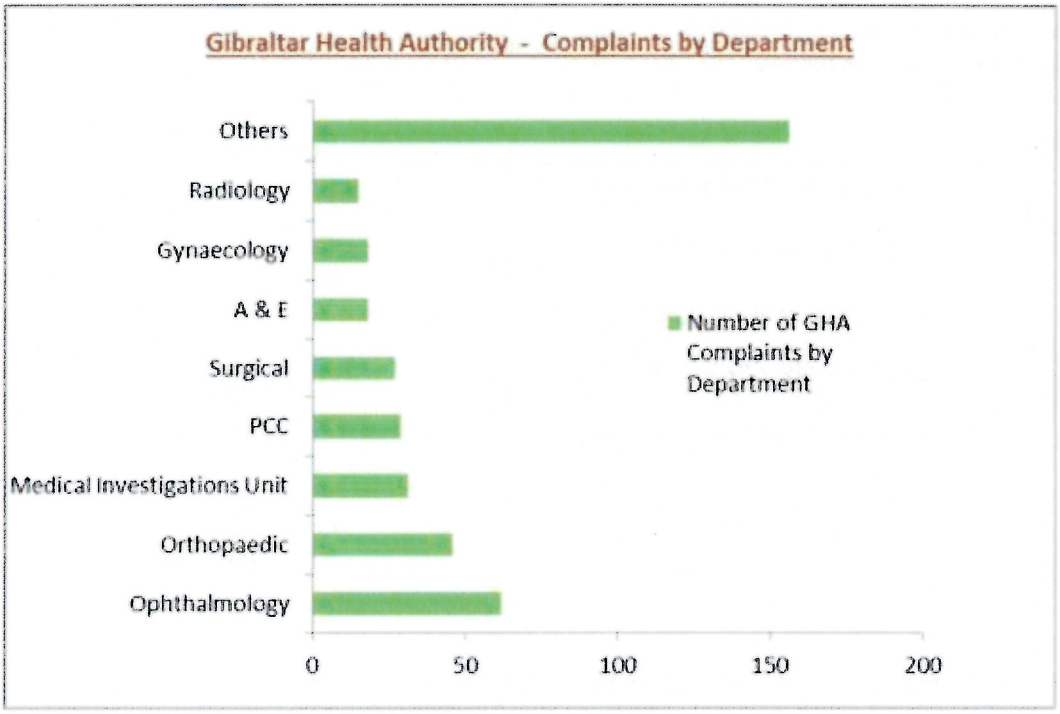
Figure 2



Of the 402 complaints received against the GHA, a total of 368 complaints were dealt with by the Complaints Handling Scheme (CHS), at the hospital, and a total of 34 complaints were dealt with directly by at the Ombudsman's Office.

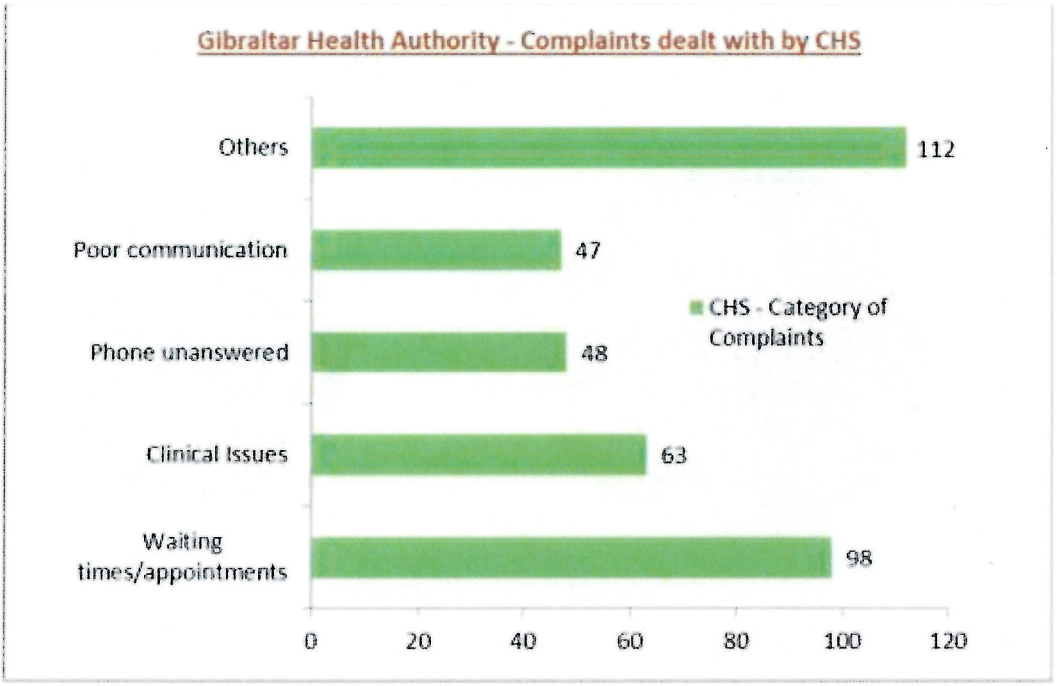
The following chart analyses the complaints received against the GHA in 2017, by department:

Figure 3



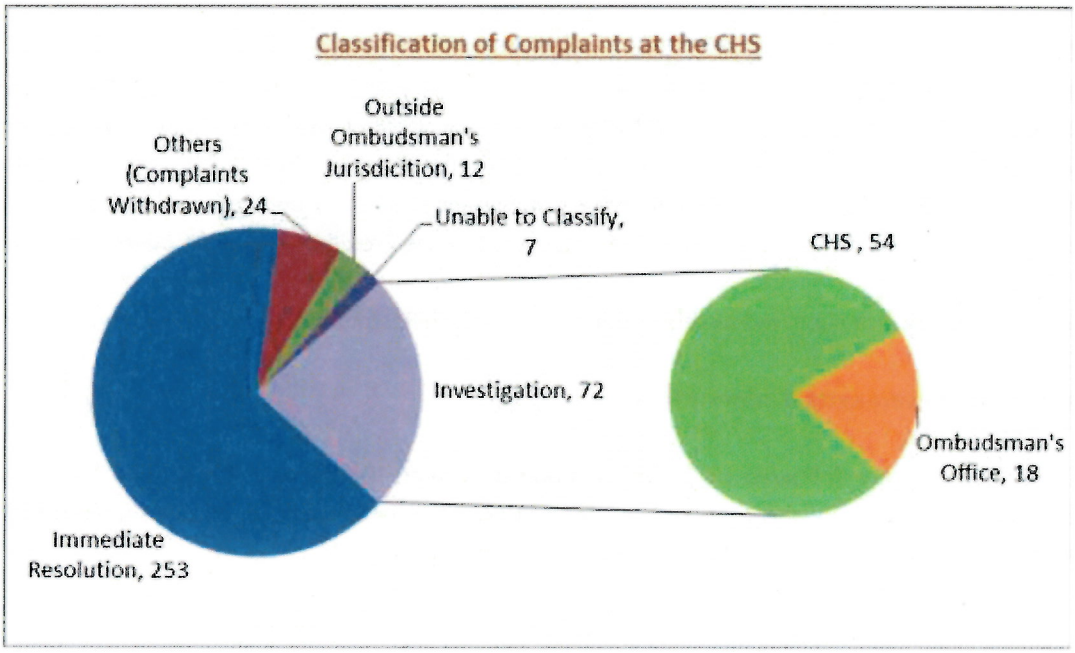
The following chart analyses the complaints received against the GHA in 2017, by category of complaints:

Figure 4



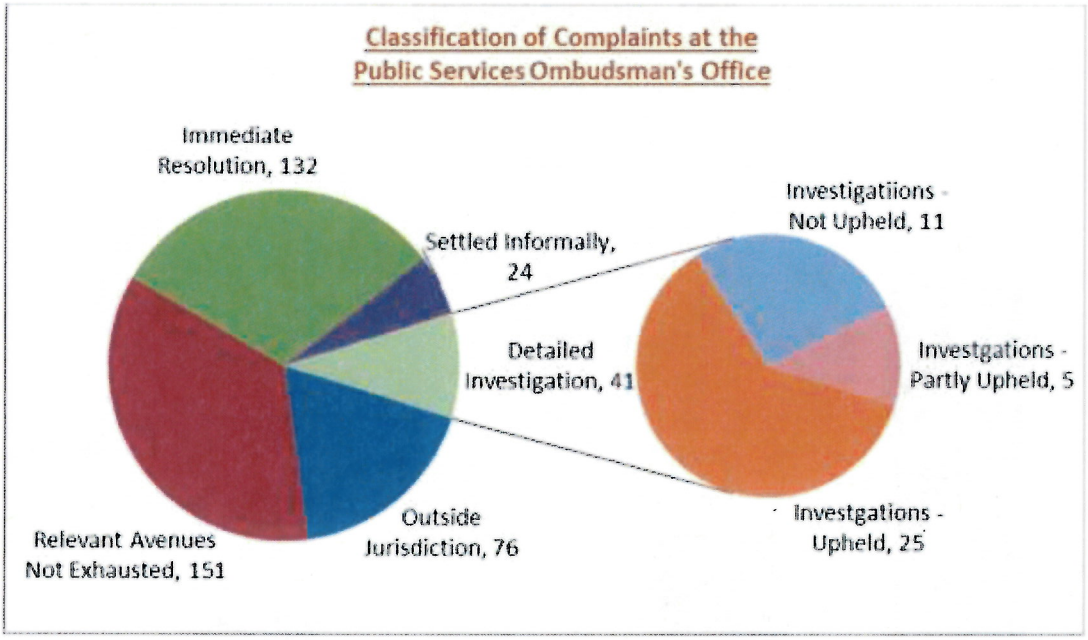
The following chart shows the classification of the 368 Complaints dealt with directly by the CHS:

Figure 5



The above chart shows that a total of 18 complaints, which were received by the CHS were subsequently passed on to the Ombudsman's Office for a more detailed investigation.

Figure 6



There were 424 complaints finalised this year, as follows:

(a) 76 complaints were classified as being 'Outside the Ombudsman's Jurisdiction';

(b) 151 complaints were closed as it was considered that there were still 'Relevant Avenues Not Exhausted' (RANE) by the Complainant with the Public Service Provider concerned. These refer to complaints that are lodged at the Ombudsman's Office without the Complainant having formally submitted their complaint to the relevant Public Service Provider, in the first instance. Before a complaint is made to the Ombudsman, the Complainant should try and resolve any issues directly with the Public Service Provider concerned under the Service Provider's own complaints procedure;

(c) 132 complaints were classified as dealt with by 'Immediate Resolution';

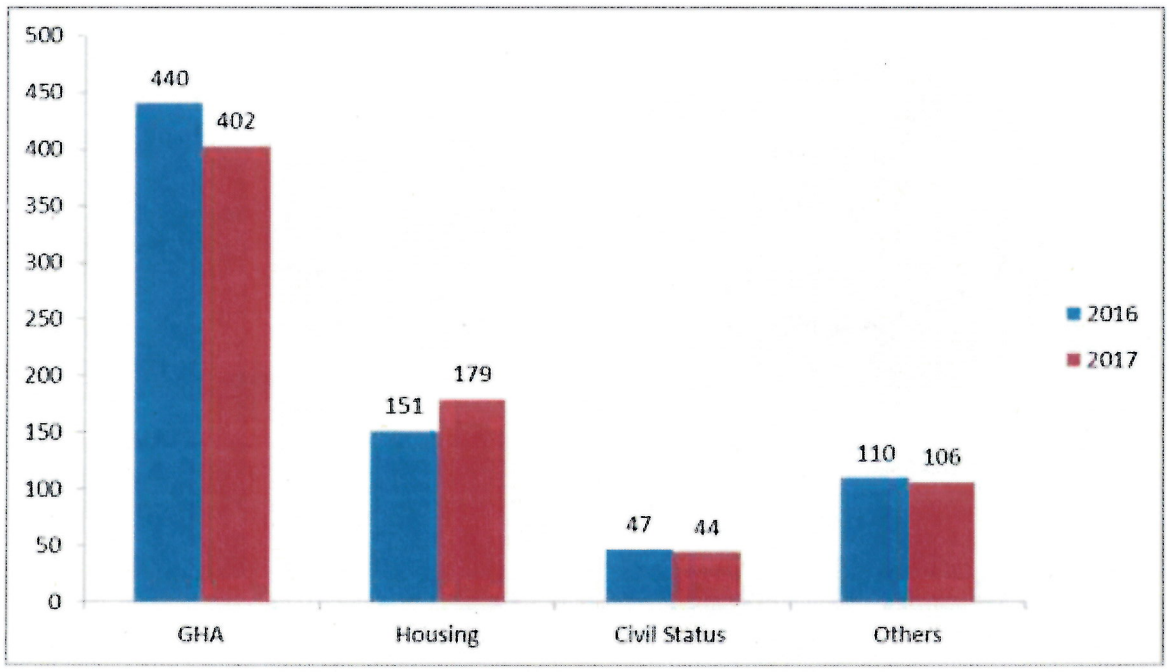
(d) 24 complaints were settled informally; and

(e) 41 complaints were followed up by the Ombudsman with 'Detailed Investigations', which were concluded by the end of the year. Out of these 41 Detailed Investigations, 25 were upheld (61%), 5 were partly upheld (12%) and 11 (27%) were not upheld.

The 'Top 3' Public Service Providers against which complaints were received in 2017 continue to be the Gibraltar Health Authority, the Housing Authority and the Civil Status and Registration Office, as follows:

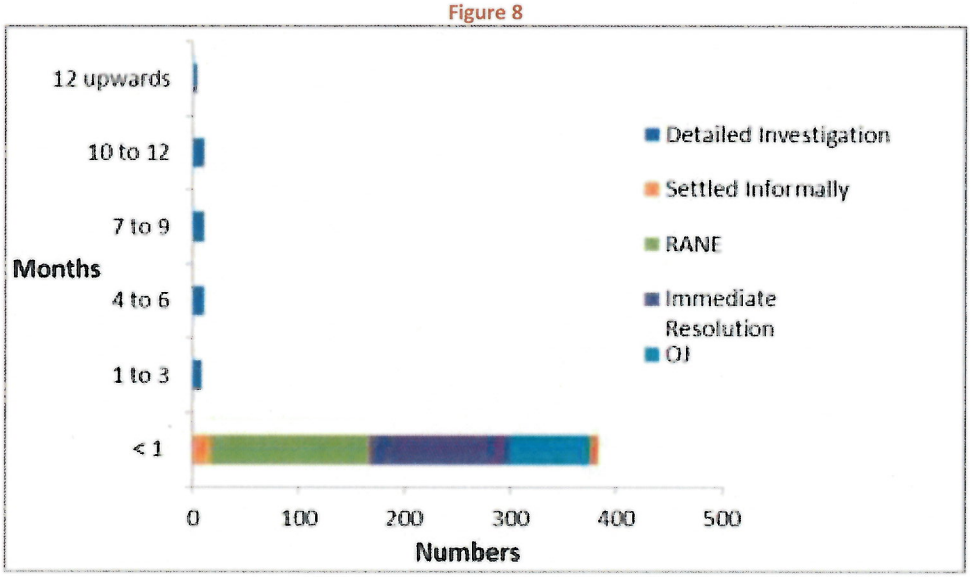
'Top-3' Public Service Providers against which complaints were received 2017 compared with 2016

Figure 7



COMPLAINTS AGAINST PUBLIC SERVICES PROVIDERS - 2017
Time Taken To Finalise Complaints

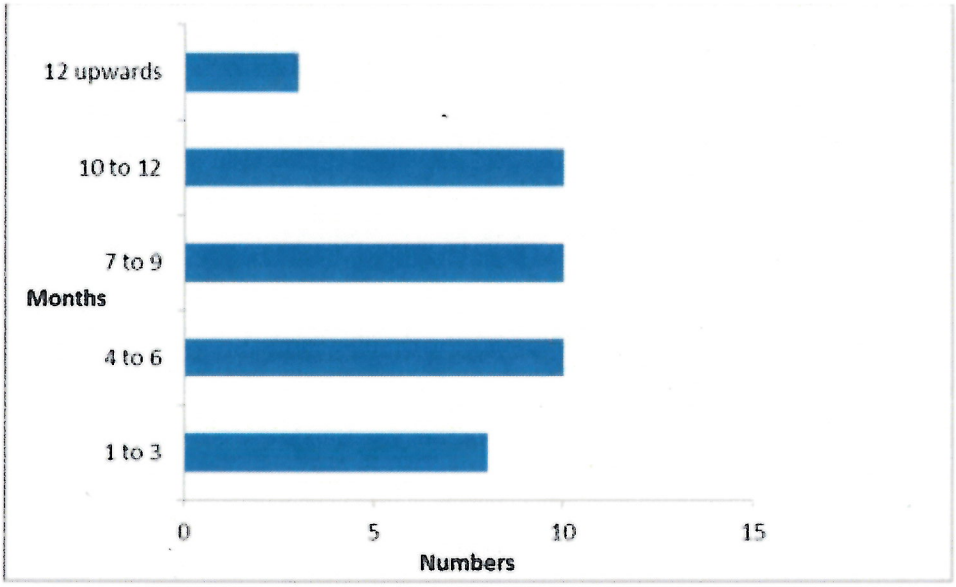
Figure 8



Of the 424 Complaints finalised during the year, 383 complaints were dealt with in less than one month; 8 complaints were finalised within three months; 10 complaints were finalised between three and six months; 20 complaints were finalised between six and twelve months and 3 complaints took more than a year to finalise.

COMPLAINTS AGAINST PUBLIC SERVICES PROVIDERS - 2017
Time Taken To Finalise Detailed Investigations – In Months

Figure 9



The above chart shows that the average time taken to complete a 'Detailed Investigation' is 7 months.